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Does Trauma-Related Training Have a Relationship with, or Impact on, Mental Health Professionals Frequency of Asking About, or Detection of, Trauma History?

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Abstract

Objective: Traumatic exposure is prevalent, with the impact of trauma and its relationship with other conditions widely documented. Research suggests that clinicians do not routinely ask about trauma history in clinical settings and trauma-related training has been recommended as a means of addressing this. The impact of such training on clinician behaviour (i.e. frequency of asking about or detection of trauma history), or the relationship between these variables, has not been formally reviewed. Method: A systematic literature review was conducted using PsychINFO, Scopus and Web of Science. The grey literature and reference lists of included articles were consulted. Nine articles met the eligibility criteria for inclusion. Results: Two-thirds of the studies reported either a statistically significant correlation between trauma-related training and detection of trauma history, or provided statistically significant evidence to suggest the following; (1) an increase in asking about, (2) more frequent asking about, and (3) greater detection of trauma histories, in mental health professionals who have received trauma- related training. Effect sizes ranged from very small to medium. Conclusions: Whilst acknowledging the limited number and variable quality of studies, as well as the failure to detect statistical significance in all studies, this review provides some evidence that trauma-related training has a relationship with or impact on clinician behaviour with regards to trauma enquiry or detection. However, further high quality research is needed. Training programmes should balance skill and educational components and consider the potential for variation in enquiry behaviour across trauma subtypes, as well as the barriers to clinician enquiry.

Keywords: trauma history, trauma-related training, mental health professionals, asking about trauma, routine enquiry

Does Trauma-Related Training Have a Relationship with or Impact on Mental Health Professionals' Frequency of Asking About or Detection of Trauma History?

It is estimated that between 51%-84% of adults in the general population have been exposed to some type of traumatic event (Bernat, Ronfeldt, Calhoun & Arias, 1998; Frans, Rimmo, Aberg & Fredrikson, 2005; Kessler, Sonnega, Bromet, Hughes & Nelson, 1995; Vrana & Lauterbach, 1994). However, traumatic exposure in clinical populations tends to be higher (Elhai, Ford & Naifeh, 2010), with evidence suggesting that between 76%-91% of individuals in clinical samples have been exposed to at least one traumatic event (Cusack, Freuh & Brady, 2004; Wota et al., 2014).

The prevalent nature of traumatic exposure in clinical samples is indicative of the impact of trauma on health and wellbeing. Traumatic exposure is associated with, and prevalent across, a range of mental health disorders and mental health difficulties (Elhai et al., 2010), including PTSD (Bunting, Murphy, O'Neill & Ferry, 2013; Lancaster, Melka and Rodriguez, 2009), substance use (Wota et al., 2014), physical health symptoms, anxiety, depression (Spertus, Yehuda, Wong, Halligan & Seremetis, 2003), personality disorders (Ball & Links, 2009; Wota et al., 2014) and psychosis (Hardy et al., 2016; Morgan & Fisher, 2007; Read, Os, Morrison & Ross, 2005). It must also be acknowledged that not everyone who is exposed to a traumatic event experiences mental health related distress (Elhai et al, 2010).

The importance of conducting a comprehensive assessment of trauma has been emphasised in the literature (Krinsley, Gallagher, Weathers, Kutter & Kaloupek, 2003). Despite this, there is a substantial body of evidence to suggest that mental health professionals do not frequently enquire about a history of traumatic exposure (Agar, Read & Bush, 2002; Cunningham et al.,

2016; Hepworth & McGowan, 2013; Mitchell, Gatson-Grindel & Laurenzano, 1996; Rossiter et al., 2015; Shannon, Maguire, Anderson, Meenagh & Mulholland, 2011). Low rates of enquiry regarding trauma history have also been observed by health professionals in health settings (McGregor, Glover, Gautam & Julich, 2010; Roberts, Lawerence, O'Toole & Raphael, 1997).

A recent systematic review by Read, Harper, Tucker and Kennedy (2018) found that only between 0 and 22% of mental health service users reported having being asked about abuse history. Additionally, only 28% of abuse or neglect histories (physical, emotional and sexual abuse and physical and emotional neglect) detected by researchers in studies were also evident in clinical notes and files. While this particular discrepancy may reflect a lack of documentation as opposed to a lack of direct enquiry by professionals, insufficient or incomplete documentation could have clinical implications for future treatment and care.

The low rates of enquiry about trauma history by mental health professionals is cause for concern, given that service users are more likely to disclose a trauma history when asked explicitly (Agar, Read & Bush, 2002; Briere & Zaidi, 1989; Read & Fraser, 1998). Consequently, the failure to explicitly ask service users about their trauma history may lead to undetected trauma histories and have ramifications for assessment, formulation and intervention (Mitchell et al., 1996). Given that traumatic exposure has been associated with other mental health presentations and disorders, the identification of a trauma history may also be useful in the formulation and treatment of other disorders or mental health difficulties (Elhai et al., 2010).

Research has explored reasons for non-enquiry by professionals. These barriers include; concerns about offending or distressing the client, the need to prioritise more immediate concerns, concerns regarding vicarious trauma, fear of inducing false memories and a lack of training in asking about or responding to disclosures (Read, Hammersley & Rudegeair, 2007).

Others include confidence in asking about and responding to disclosures (Mansfield, Meehan, Forward & Richardson-Clarke, 2017), while clinician and client gender, client age and diagnosis have also been found to influence professionals enquiry (Cunningham et al., 2016; Read et al., 2007; Shannon et al., 2011).

It is notable that research has failed to conclude that asking clients about potentially traumatic events causes significant distress (Elhai et al., 2010). However, this does not negate the need for clinicians to be sensitive and cautious in their enquiry. Clinicians should explain the importance and relevance of enquiry and facilitate the process therapeutically, particularly if a disclosure is made (Elhai et al., 2010). This process may be facilitated by self-report or clinician administered instruments to assess exposure to traumatic events (Elhai et al., 2010).

The low rates of enquiry regarding trauma history by mental health professionals has led to a number of recommendations including the development of guidelines, policies and training programmes to improve enquiry and response to trauma history disclosures (Cunningham et al., 2016; Mansfield et al., 2017; Read et al., 2018; Rossiter et al., 2015; Shannon et al., 2011). One of the most prominent initiatives in the literature is the New Zealand Training programme. This programme was designed by mental health services in conjunction with the University of Auckland in response to a best practice policy document for trauma and sexual abuse (Cavanagh, Read & New, 2004). This programme will be discussed later in the review.

Aim of current review

Low rates of trauma history enquiry by mental health professionals have been met with a resounding recommendation that mental health professionals receive training to address this. In order to evaluate the utility of this training, it is important to ascertain if trauma-related training is

related to, or has an impact on, mental health clinicians enquiry, or detection of, trauma history. This has not yet been formally reviewed.

With the above in mind, the primary aim of this systematic review is to consider if trauma-related training, delivered to mental health professionals, has a relationship with, or impact on, mental health clinician behaviour (i.e. frequency of asking about or the detection of trauma history). Secondly, important components of training programmes will be identified in order to make recommendations for the designing of effective training programmes. The findings of this review may have important implications with regards to the development and provision of future trauma-related training programmes for mental health professionals.

Method

Search strategy

The protocol for this systematic literature review was registered and published with prospero (registration number: CRD 42017077523). A literature search was conducted in November 2017, using Scopus, Web of Science and PsychINFO. As per PRISMA guidelines (Liberati et al., 2009), the search terminology for one database is presented as follows (Web of Science): training or program* and trauma or abuse or neglect or maltreatment or violence or “sexual assault” or “physical assault” or “domestic violence” or “intimate partner violence” or “sexual violence” and “mental health profession*” or “mental health staff” or “healthcare profession*” or psychiatric or “mental health service” and ask* or detect* or "training experience$” and analys?s or survey or questionnaire or file or form or audit or evaluation or record* or simulation or "case vignette" or assess*. Truncation and wild card symbols were

amended as per guidelines for PsychINFO and Scopus databases. Subject headings were used in PsychINFO and combined using "or" with the key words above (See Appendix A).

A hand search of the grey literature was also conducted in November 2017 using Google scholar and also, via an online source *("Grey Literature Report"*, n.d.). No additional records were obtained. A total of 1,283 publications were identified using database searches (424 from Scopus, 223 from Web of Science and 636 from PsycINFO [1806-present]. 1,096 records remained following the removal of duplications and the abstracts and titles were screened according to eligibility criteria as follows:

i. Studies that evaluated the impact of trauma-related training on mental health clinicians enquiry behaviour (i.e. examined change in frequency of asking about or detection of trauma history from pre-to-post, or examined differences in enquiry behaviour between mental health professionals who received training (i.e. intervention) and mental health professionals who had not received training (i.e. control).
ii. Studies investigating the relationship between trauma-related training and frequency of asking about trauma history or detection of trauma history
iii. Participants who are mental health professionals, or professionals working in mental health services who work as part of a team or service to provide or contribute to a mental health service. Studies including professionals who did not provide or work as part of a team or service delivering a mental health service were excluded (e.g. health care professionals, physicians in general health/hospital settings).
iv. "Trauma-related training" was defined as training in the area of trauma delivered in any format, to mental health professionals. Training could be specifically related to, or tailored to, specific types of trauma histories e.g. domestic violence, sexual abuse,

emotional abuse, physical abuse or more general. Trauma-related training could be part of the mental health professionals initial professional training, additional to professional training, or provided to a service as part of a service initiative or training policy.

v. The outcome measures for this review (i.e. frequency of asking about trauma history or detection of trauma history) could be captured by any means, for example by professional self-report (i.e. survey, questionnaire), documented or recorded in clinical files/notes or via service audits.

vi. Published and unpublished studies in the form of journal articles, service related/research evaluations or reports and dissertations. Books, book chapters or other reviews were excluded.

vii. Studies published in English. Studies in other languages were excluded.

viii. Quantitative studies, including surveys or questionnaires incorporating open-ended questions and responses. Qualitative studies were excluded. It is noted that only quantitative studies were identified in the review process with neither of these studies addressing the question of this review.

Following completion of the screening process, 39 potentially suitable articles were identified and the full texts were then retrieved for full review. From the remaining 39 articles, 32 did not meet the eligibility criteria, leaving seven articles identified as meeting all criteria. The reference lists of articles meeting the inclusion criteria were then hand searched for additional relevant articles. A further five full text papers were assessed for eligibility with two of these articles meeting the criteria for inclusion in the study. Three international dissertations were also identified via the references of included texts. The authors of these dissertations were contacted and replies from two of the three corresponding authors confirmed that these

dissertations would not have met the eligibility criteria of this study; the third dissertation was not retrievable.

A total of nine articles meeting the criteria were included in the review and a visual representation of the search process is presented in Figure 1. A second rater assessed eligibility for inclusion and Cohen's Kappa inter-rater reliability was calculated at .87, indicating almost perfect agreement (McHugh, 2012). Any discrepancies were resolved through discussion.

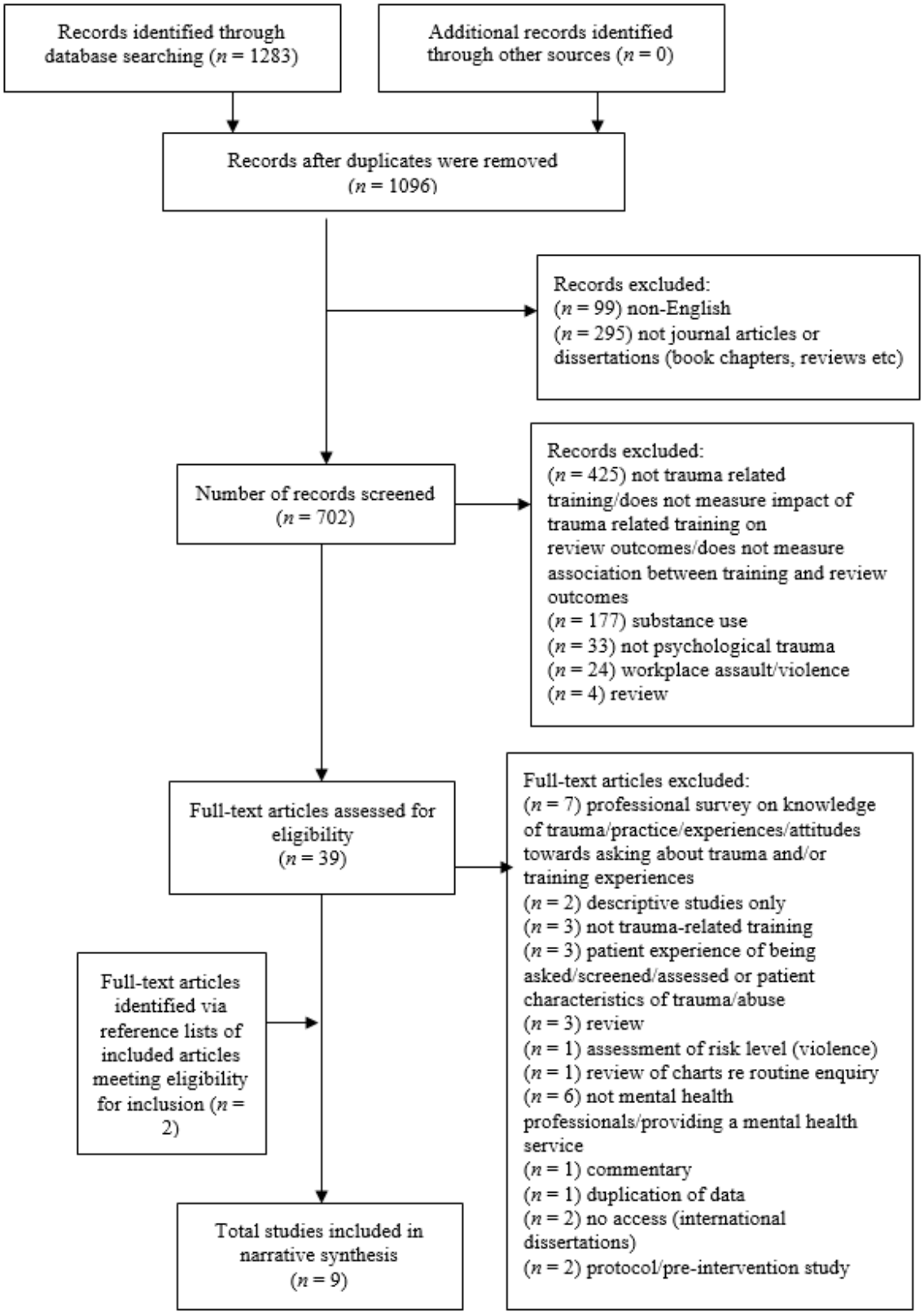

Figure 1. PRISMA flow diagram of search process. Adapted from Liberati et al. (2009)

Given the small number of articles meeting the inclusion criteria of the review, quality appraisal was conducted on the included articles in order to assess the quality of these studies, rather than to eliminate studies from the review. To accommodate a range of study designs, it was necessary to incorporate items from the Quality Assessment Tool for Before-After (Pre-Post) Studies with No Control Group and the Quality Assessment Tool for Observational Cohort and Cross-Sectional Studies, both developed by the National Heart, Lung & Blood Institute in 2014 (NHLBI, 2014a; NHLBI, 2014b), and STROBE guidelines (Strengthening the Reporting of Observational studies in Epidemiology; von Elm et al., 2007). The Centre for Reviews and Dissemination (CRD, 2008) guidelines informed items included in the tool.

Studies were assessed using nine items based on a three quality rating system informed by the Scottish Intercollegiate Guidelines Network guidance (SIGN, 2011). Higher scores were indicative of higher quality and the nine items were scored as follows: 2 = well covered, 1 = adequately addressed, and 0 = poorly addressed, not addressed, not reported or not applicable. A copy of this critical appraisal checklist can be found in Appendix B. Study quality was also assessed by a second rater and discrepancies were resolved through discussion. See Table 1 for quality scores.

Total scores used to inform an overall quality category for each individual study, using the NHLBI (2014) coding criteria of “good”, “fair” or “poor”. “Good” studies have the least amount of bias and results are considered valid, “fair” studies are susceptible to some bias but not sufficient to warrant an invalidation of results, while “poor” studies have a significant risk of bias (NHLBI, 2014a; NHLBI, 2014b). Studies varied in their level of quality, with only two studies identified as “good”. The main limitations pertaining to each study, as identified via the quality assessment, will be highlighted in the synthesis of findings.

Table 1

Quality appraisal scores and categories

Study	Aims	Population	Sample size	Intervention exposure	Outcomes	Time frame	Discussion	Confounding	Statistics	Quality Category
Cavanagh et al. (2004)	2	2	1	2	1	0	1	1	1	Fair
Sampson & Read (2017)	2	2	1	1	1	1	2	1	2	Good
Lotzin et al. (2018)	2	2	2	2	1	2	2	2	2	Good
Donohoe (2010)	2	2	1	1	0	0	2	0	0	Poor
Walters, Hogg & Gilmore (2016)	2	2	0	2	1	2	2	1	2	Fair
Currier & Briere (2000)	2	1	0	1	2	0	0	2	1	Fair

Study	Aims	Population	Sample size	Intervention exposure	Outcomes	Time frame	Discussion	Confounding	Statistics	Quality Category
Young, Read, Barker-Collo & Harrison (2001)	1	2	1	0	1	0	2	1	1	Fair
Murray et al. (2016)	1	2	1	0	0	0	2	1	2	Fair
Currier, Barthauer, Begier & Bruce (1996)	2	1	1	0	0	0	1	0	0	Poor

Results

Synthesis of results

Table 2 provides a summary and key results of each study. Six of the nine studies included in this review set out with the overall aim to evaluate the effectiveness of a training intervention on various outcomes (Cavanagh et al., 2004; Currier & Briere, 2000; Donohoe, 2010; Lotzin et al., 2018; Walters et al., 2016), including one which investigated the impact of a longstanding and existing training policy and intervention within a service (Sampson & Read, 2017). Two studies examined training needs and experiences of mental health professionals (Currier et al., 1996; Murray et al., 2016), while the final study predominantly focused on identifying barriers in obtaining abuse histories (Young et al., 2001). With regards to design, four studies employed a cross-sectional design, whilst the remaining five studies adopted an experimental approach.

In relation to participant demographics, participants, who were mental health professionals, (N = 780), ranged between 18-65 years in age, with the majority of professionals reported to be female. Details on age and gender were not provided in three studies (Currier et al., 1996; Currier & Briere, 2000; Walters et al., 2016) and the number of professionals in the Sampson & Read (2017) study could not be determined due to the methodology (e.g. file analysis).

As evidenced from Table 2, the nature and source of trauma-related training provided to clinicians varied across studies. For the majority of the six studies evaluating the impact of a specified training intervention or programme, training was in addition to professionals initial training (Cavanagh et al., 2004; Currier & Briere, 2000; Donohoe, 2010; Lotzin et al., 2018; Walters et al., 2016). In two of these studies, participants were randomised to either a training group or control group (Currier & Briere, 2000; Lotzin et al., 2018). Three studies examined training experiences more generally (Currier et al., 1996; Murray et al., 2016; Young et al., 2001.

While the source of this training was part of clinical training for many professionals in one study (Currier et al., 1996), this was not ascertained in the remaining two studies. In the three studies which examined training experiences more generally, little information was available with regards to the details of the training received (e.g. Currier et al., 1996; Murray et al., 2016; Young et al., 2001).

Across all studies, training tended to be either trauma-generic or focused on specific traumatic experiences, such as domestic violence, sexual abuse or abuse histories, with some training programmes covering a culmination of traumatic experiences. With regards to training content and format, as limited information was available on training received by participants in studies which did not directly evaluate a specific training programme, it was unknown if participants' training experiences in these studies directed a focus on how to ask about trauma history (Currier et al., 1996; Murray et al., 2016). This was more explicit in the Young et al. (2001) study, as participants were asked directly if they had received training in relation to asking about abuse.

In the six studies where a training programme was being evaluated, the components of trauma-related training varied across studies, but usually consisted of some educational content (e.g. summary of research findings regarding trauma/abuse, information and guidance on various aspects of trauma including assessment/enquiry), with some studies also incorporating a focus on practical skill development in asking about trauma history and responding to disclosures (Cavanagh et al., 2004; Donohoe, 2010; Lotzin et al., 2018; Sampson & Read, 2017). One study also incorporated information regarding trauma interventions (Walters et al., 2016). Additionally, training tended to be delivered in group format, with the duration of training ranging from a one-hour trauma orientation to a full day training programme with an additional refresher session.

In total, four of the nine studies used surveys or self-report questionnaires to examine clinician frequency of asking about trauma history (Lotzin et al., 2018; Cavanagh et al., 2004; Donohoe, 2010; Walters et al., 2016). One study (Young et al., 2001) employed a case vignette to assess clinician enquiry behaviour in addition to a self-report questionnaire, which was used to collect other information, including training exposure. Two studies (Currier et al, 1996; Murray et al., 2016) used self-report questionnaires to measure both clinician enquiry behaviour and capture training experiences simultaneously. Of the remaining two studies, one study compared trauma history detection rates obtained using a standardised trauma interview (Currier & Briere, 2000) while the final study employed a file audit (Sampson & Read, 2017). A diverse range of analytic methodologies were employed across the studies including t-tests, descriptive statistics, chi-square analyses, linear mixed modelling, as well as a correlational design. The first author of this review calculated the effect sizes for studies where this had not been conducted.

A narrative synthesis of the key results of the studies relevant to the research question is explored using the following headings: specified trauma-related training programmes and generalised trauma-related training experiences

Table 2

Summary of key results

Author and design	Participants (age, gender and profession)	Training details (duration, format, type of trauma covered, content)	Data collection instruments	Key results
Cavanagh et al. (2004) Quasi-experimental (pre-post).	*N* = 85. 53% nurses, remainder therapist/psychotherapists, psychologists, social workers, occupational therapists, psychiatrists and support workers. Majority aged 30-39 years. 73% female; 27% male.	A one-day group training programme (New Zealand training programme), focusing on childhood physical and sexual abuse. Consisted of group discussion, educational components (research summary, link between abuse and mental health, prevalence and effects of abuse) as well as practical skill development in asking and responding to disclosures.	Self-report questionnaire pre and six weeks post- training (*n* = 31).	No significant self-reported change in number of clients known to professionals to have an abuse history from pre to post-training (i.e. no change in detection rates). (Unable to detect effect size).

Author and design	Participants (age, gender and profession)	Training details (duration, format, type of trauma covered, content)	Data collection instruments	Key results
Sampson and Read (2017) Quasi-experimental.	Initial assessments conducted by psychiatrists, nurses, psychologists and other. 62% of female; 38% male.	A one-day group training programme as described in Cavanagh et al. (2004). This training was delivered several times annually for approx. nine years.	File audit of 250 randomly selected files. Comparison of detection rates to 1997 audit of 200 files (Agar et al., 2002).	Statistically significant increases of recorded child sexual abuse ($\Phi = 0.13$), child physical abuse ($\Phi = 0.22$), adult sexual abuse ($\Phi = 0.12$) but not adult physical assault (Unable to calculate effect size).
Lotzin et al. 2018 Cluster randomised control design.	$N = 148$. 70.2% of sample were social pedagogues, remainder were pedagogues, psychologist, trainees and "other" recruited from substance use service. Age of intervention group in years ($M = 42.9$); age of control group in years ($M = 42.0$).	A one-day group programme with additional refresher session three months post training in relation to neglect, physical sexual and emotional abuse. Training was the "Learning how to ask" training (Read et al., 2007) based on the New Zealand training programme, as described in	Self-report questionnaire at baseline ($n = 132$), 3-month ($n = 104$) and 6-month follow-up ($n = 74$).	Self-report change of frequency of enquiry about trauma was significantly greater (from baseline) at three month and six month follow-up in the intervention group than controls ($B = 0.43$). No significant change from

Author and design	Participants (age, gender and profession)	Training details (duration, format, type of trauma covered, content)	Data collection instruments	Key results
	Female (*n* = 79); male (*n* = 52).	Cavanagh et al. (2004). Service providers randomly allocated to intervention (*n* = 72) or control (*n* = 76).		three month to six month follow- up (*B* = 0.02)
Donohoe (2010) Cross sectional	*N* = 53. Staff nurses, ward management, social workers, community psychiatric nurses, occupational therapists, support and recovery workers, physio, health care assistant, co-morbidity nurse, technical instructor. 20% Male; 80% Female. Age range 27-61 years.	The Victims of Violence and Abuse Prevention Programme (Department of Health) consisted of a one-day group training and education programme to improve enquiry and response to sexual abuse histories. Consisted of the provision of education surrounding sexual abuse (both victims and perpetrators), alongside practical skill development in enquiry and response.	Self-report questionnaires (*n* = 30).	77% of professionals felt that the training had changed their practice with over 35% of these professionals reporting that since the training, they were now asking clients about abuse as part of their routine assessment.

Author and design	Participants (age, gender and profession)	Training details (duration, format, type of trauma covered, content)	Data collection instruments	Key results
Walters et al. (2016) Quasi-experimental (pre - post)	*N* = 14. Early Intervention for Psychosis Service staff including Management, Psychology, Nursing, Social Care and Care co-ordinator. No details on gender or age.	Half-day group training programme focusing on trauma. Consisted of the delivery of information on trauma assessment and intervention (including guidance and skills in phase based approach to treatment), trauma and attachment, case discussion and problem solving.	Self-report questionnaire One-month pre-training, post training and six month follow up). Data for all time points (*n* = 7).	No significant self-reported change in enquiry about trauma (*d* =.6) or significant change in the number of clients known to have a trauma history from pre -intervention to six month follow up (*d* = .8).
Currier and Briere (2000) Experimental	*N* = 18 psychiatric emergency department clinicians including medical students, psychiatric residents, psychiatric nurse and	One-hour trauma orientation lecture delivered by second author. Consisted of information on the prevalence of trauma, victimisation as well	Trauma history assessed by clinicians using standardised trauma interview. Comparison in	Clinicians receiving the orientation detected significantly more sexual (Φ = 0.22), physical (Φ = 0.21), total violence (Φ = 0.17) and greater detection

Author and design	Participants (age, gender and profession)	Training details (duration, format, type of trauma covered, content)	Data collection instruments	Key results
	psychologist. Random allocation to trauma orientation (n = 10) or control (n = 8). No details on gender or age.	as the impact and the assessment of trauma. Control group received no information on trauma.	detection rates made between those who received training and control.	of childhood sexual abuse (Φ = 0.26) and childhood physical abuse (Φ = 0.16). No significant difference between groups in detection of childhood/adolescent peer sexual assault (Φ = 0.06), adult spouse abuse (Φ = 0.08), adult non-intimate physical assault (Φ = 0.11) or adult sexual assault (Φ = 0.14).
Young et al. (2001) Cross-sectional	N = 144. Psychologists and Psychiatrists 55% female; 45% male Age (M = 43; SD = 10.3)	Participants were asked via survey item “Have you ever received any training regarding how to enquire about abuse?”	Self-report questionnaire and case vignette.	Participants with training (76%) were significantly more likely to ask about abuse in a case vignette (g = 0.75).

Author and design	Participants (age, gender and profession)	Training details (duration, format, type of trauma covered, content)	Data collection instruments	Key results
		No details on content of training available.		
Murray et al. (2016) Cross-sectional	*N* = 173. 41.6% Marriage and Family Therapists. Remaining sample included Clinical Social Workers, Psychologists, Counsellors, Substance abuse specialists, Advocates, Psychiatrists and other (not specified).74.6% Female; 23.1% Male. Age range 18-65 years, majority aged 55-64 years.	78.6% of participants had domestic violence training. For the majority of these professionals, this training was eight hours or less, ≤2 years ago. 94.8% of participants had trauma-related training. For the majority of these professionals, this training was between ≤8 hours and 9 - 16 hours, ≤2 years ago. No details on content of training available.	Self-report survey.	Professionals with domestic violence training were statistically more likely to screen all clients for domestic violence (Φ = 0.22), screen for partner sexual abuse (Φ = 0.19), screen for trauma symptoms (Φ = 0.23) and enquire about historical domestic violence (Φ = 0.24). No significant group differences regarding the screening of other types of trauma (Φ = 0.08) or with regards to the tendency to

Author and design	Participants (age, gender and profession)	Training details (duration, format, type of trauma covered, content)	Data collection instruments	Key results
				screen for domestic violence (Φ = 0.11) or other types of trauma if suspected (Φ = 0.07).
Currier et al. (1996) Cross-sectional	*N* = 145 psychiatric residents at 4 medical schools. No details on gender or age-	28% had received training on domestic violence, either in medical school (13%), during residency (19%) and from other sources (8%). Between 9.9 and 11.3 hours of training on domestic violence received. No details on content of training available.	Survey.	Case detection was significantly correlated with training in domestic violence (*r* = .30). 88% of those who received training detected six or more cases of domestic violence in the past year in comparison to 48% of those who had not received training (Φ = 0.35).

Specified trauma-related training programmes.

New Zealand training programme/"Learning how to ask training"

Three of the nine studies included in this review evaluated the effectiveness of the New Zealand training programme, which was provided in addition to professional clinical training. The programme initially focused predominantly on physical and child sexual abuse, with the aim to improve clinician enquiry and response to trauma and abuse histories (Cavanagh et al., 2004). This one-day group training programme encompassed educational components, including research summaries of the relationship between abuse and mental health, the prevalence and effects of abuse, research demonstrating how often mental health professionals are asking about abuse and included discussions reflecting on the advantages and disadvantages of asking about abuse histories, as well as practical skills in enquiry and responding to disclosures (Cavanagh et al., 2004).

Cavanagh et al. (2004) employed a self-report questionnaire, which was administered immediately prior to the training and six weeks post training to provide the first evaluation of the programme ($N = 85$). While a statistically significant increase in confidence in asking about abuse and in responding to disclosures was observed, no statistically significant change in the number of clients known to clinicians with a sexual abuse history was observed. It was not possible to calculate an effect size for this particular finding as the statistical information could not be retrieved. However, training was well received by participants, with 67% of participants reporting that training had changed their clinical practice. A small number of participants provided some examples of specific changes in this regard ($n = 17$), which included "now I ensure that either myself or someone else working with the client asks about abuse" and "I tend to ask the question quite early on in therapy" (Cavanagh et al., 2004, pp. 141).

The failure to detect statistically significant results may have been contributed to by a number of factors, including the small number of participants for whom pre and post-data were available (n = 31), as well as an insufficient time period in which to expect a change (six weeks). Alternatively, it may be that participants were already demonstrating a high level of skill in enquiry prior to the delivery of the training programme, given that 33% of participants in the study had received additional training prior to the intervention in this regard, thus making it difficult to detect a significant change. Cavanagh et al. (2004) acknowledged these limitations. Findings in this study also indicated that client diagnosis, gender and age of client continued to influence professionals decision as to whether or not to ask clients about their abuse history post-training. However, as acknowledged by Cavanagh et al. (2004), this represented a minority of professionals, perhaps in part due to the limited post data available.

A further evaluation of this programme was conducted by Sampson and Read (2017), who compared detection rates of sexual and physical abuse to those obtained in a previous audit (see Agar et al., 2002), which had been undertaken in 1997 prior to the introduction of a policy and requirement that mental staff attend training on enquiring about childhood trauma (i.e. the New Zealand training programme). At the time of this study, the training programme had been running a number of times per year for approximately nine years.

Following an audit of 250 randomly selected files from four community health centres, the authors found a statistically significant increase in rates of recorded child sexual and physical abuse, and adult sexual abuse, but no statistically significant increases in recorded rates of adult physical assault were observed. The author of this review calculated effect sizes using phi coefficients, revealing small effect sizes with regards to detection of child sexual and physical abuse, and adult sexual assault. Effect size could not be calculated for adult physical assault. Additionally, female clinicians were statistically more likely to ask about

trauma history at initial assessment than males and clients with psychosis were less likely to be asked. Despite the significant improvements, 34.8% of the audited client files revealed no indication of having been asked about trauma history by a professional at any stage of treatment. Findings need to be considered in relation to the difficulty attributing increased rates of recorded abuse (i.e. increased detection) directly to the training, given that the design of the study did not allow the potential contribution of other variables to be measured or controlled.

Lotzin et al. (2018), using a cluster randomized control trial, investigated the impact of an adapted form of the New Zealand training programme referred to as the "Learning how to ask training" (Read et al., 2007) on a range of outcomes. In line with the New Zealand training programme, the objective of the training was to increase clinicians frequency of asking about a range of traumatic experiences including neglect, physical, sexual and emotional abuse. In addition to the existing training components associated with the New Zealand training programme outlined previously, this one-day group training programme was adapted for the German language and incorporated a refresher session three-months post-training. The additional session consisted of discussions regarding experiences of asking about, and responding to, as well as a reminder on how to ask about trauma. Service centres were randomly allocated to either the intervention (n = 72) or control group (n = 76).

Using a self-reported questionnaire, participants who received the training reported a significantly greater change in frequency of asking about trauma history from baseline to three and six-month follow-up than those who were in the control group. A medium effect size estimate was observed in this regard. No significant change was observed between three and six month follow up suggesting that change was maintained (very small effect size estimate). Statistically greater increases in knowledge about trauma, attitudes and confidence with regards to enquiry and response were observed in the intervention group in comparison

to the control. The authors also found that whilst enquiry for all trauma types significantly increased for those who received the training programme, sexual abuse was asked about significantly less than other trauma types in both the intervention and control group. Gender, duration working in the centre, profession and previous trauma training, did not significantly predict change in frequency of asking about trauma. However, change was predicted by clinician age, with older clinicians more likely to have reported a change in frequency of asking. While the authors acknowledge various limitations associated with the study, such as the reliance on self-report questionnaires, this study achieved one of the highest quality ratings in this review.

Other specific training programmes

Donohoe (2010) provided an evaluation of the Victims of Violence and Abuse Prevention Programme in one of the pilot trusts ($N = 53$). This programme, which was provided in addition to professional training, focuses on sexual abuse and aimed to equip clinicians with knowledge and skills in enquiry and response to disclosure. The training, which was delivered over one day in group format, consisted of the provision of education surrounding sexual abuse (both victims and perpetrators), alongside skill development for enquiry and response to sexual abuse history.

Using a self-report questionnaire administered post-training (no time period specified), 77% of mental health professionals agreed that the training had changed their clinical practice, with over 35% reporting that they were now asking about abuse history as part of their routine assessment. Participants also reported other changes, including having more confidence and more knowledge and awareness of abuse.

In addition to the above findings, over one-third of professionals (36%) in the study identified psychosis, delusions, mania, paranoid and cognitive impairments, as factors that

would discourage asking about abuse history. Age of client was also found to influence decision to ask about sexual abuse history for 21% of clients in the study, with 60% of these professionals reporting that older people were harder to ask. Finally, 38% of professionals felt that the gender of clients influenced whether or not they asked, with 91% of these professionals reporting to find it more difficult to ask males. However, the findings of this study are compromised by the small number of professionals who completed the questionnaire (n = 30), the reliance on descriptive statistics due to the lack of pre-training measures, the limited information reported regarding the questionnaire and time frame in which the questionnaire was completed following the training. Additionally, there may be some difficulty in attributing results to the training delivered, given that 50% of professionals in the study reported to have received prior training in abuse enquiry.

Sample size was also a concern in the Walters et al. (2016) study, which aimed to evaluate the effectiveness of a bespoke training programme developed in response to staffs' needs identified via a focus group (N = 14). This programme, which was additional to professionals initial training, aimed to improve knowledge about trauma (non-specified type), confidence in asking about and responding to trauma and reduce staff worries regarding assessment and treatment of trauma. The training consisted of a half-day programme, delivered in group format and consisted of education on trauma assessment and intervention strategies (including guidance and skills on phase based approach to treatment), relationship between trauma and attachment, case discussion and problem solving.

Using a self-report questionnaire, no statistically significant change in the number of clients known to professionals with a trauma history was observed from pre-training (one month prior to training) to six-month follow-up. Similarly, there was no statistically significant self-reported change in professionals frequency of asking about trauma history from pre-training to follow up. This is despite the fact that the mean number of clients known

to have a trauma history and the mean rate of enquiry about trauma history increased from pre to follow-up, and medium effect sizes were observed, as calculated by the author of this review. Given the effect sizes observed, failure to find statistically significant differences may be due to the limited data available for all time points (n = 7), a limitation acknowledged by the authors. However, it must be acknowledged that despite the limited sample, statistically significant improvements in staff confidence and knowledge in assessing and treating trauma were observed. The authors also acknowledge the potential impact of staff restructuring on findings which occurred following the training (Walters et al., 2016).

Currier and Briere (2000) evaluated the impact of a brief trauma-related training intervention in a psychiatric emergency department. The intervention, which was designed to test the hypothesis that trauma training results in improved case detection and was not part of professionals clinical training, consisted of a one-hour trauma educational lecture on the prevalence of trauma, victimisation as well as the impact and assessment of trauma. Participants were randomly allocated to the intervention (n = 10) or to a control group (n = 8), where participants received no information on trauma.

Using a standardised trauma interview, clinicians who received the trauma orientation detected significantly more trauma history (sexual, physical and total violence) than those in the control group. Follow-up analyses revealed that clinicians who received the orientation detected significantly more childhood sexual and physical abuse, but not childhood/adolescent peer sexual assault, adult spouse abuse or adult non-intimate physical assault, than those in the control group. Effect size calculations were calculated by the authors, which revealed small effect sizes for each of the above findings.

In addition to the above findings, female clinicians detected significantly more sexual violence than male clinician. However, neither clinician age nor education level had a significant effect on number of instances of sexual, physical or total violence detected per

clinician. While findings led the authors to support the effectiveness of a brief trauma orientation on detection of trauma history, limitations included the small sample size (N = 18), insufficient details regarding time frame of the study (i.e. how long after the orientation detection was evaluated) and the lack of follow-up to ascertain if effects were maintained post-intervention.

Generalised trauma-related training experiences

The remaining studies in this review did not set out to evaluate a specific training programme. Rather, they enquired about trauma-related training previously received by participants (i.e. exposure), predominantly via self-report questionnaire, and sought to establish whether this was associated with or related to clinician frequency of asking about or detection of trauma history.

Young et al. (2001) employed a self-report questionnaire and case vignette to investigate barriers to asking about abuse histories in a sample of Psychiatrists and Psychologists (N = 144). A survey item asked professionals if they had received training regarding abuse enquiry, to which 24% of professionals responded that they had not received training in this regard. The source of this training was not specified.

Young et al. (2001) found that participants who had received training in abuse enquiry were significantly more likely to ask about abuse in the case vignette. The authors of this review calculated the effect size using Hedges g, which revealed a medium effect size in this regard. Neither clinician gender, nor years of clinical experience, profession or etiology beliefs, had a significant impact on probability of enquiry about abuse in the vignette. Results must be interpreted in light of the limited information obtained with regards to the content and format of training received by participants, as well as the simultaneous measurement of training exposure and clinician enquiry behaviour.

Murray et al. (2016) distributed a self-report survey to mental health professionals to ascertain domestic violence training and experiences (N = 173). 78.6% of professionals reported to have received domestic violence training and 94.8% of professionals reported to have received more general trauma-related training. The source of this training was not specified. Details regarding when such training was received and duration are provided in Table 2. Professionals who had received domestic violence training were statistically more likely to report screening all clients for domestic violence and screening for partner sexual abuse and trauma symptoms. Professionals with training also engaged in a statistically higher number of intervention practices, including enquiry about historical domestic violence. There were no significant differences between trained and untrained professionals with regards to the screening of clients for other types of trauma, or with regards to the tendency to screen for domestic violence or traumatic violence only if suspected. Effect size calculations, using phi coefficients, were conducted by the authors of this review and ranged from very small to small effect sizes for all findings.

Limitations of the above study include the fact that the term “screening” was not defined by the questionnaire despite participants screening practices being under investigation. As a result, there may have been variation in how participants interpreted and responded to this. The study also did not capture any information on training content and format. Additionally, the overrepresentation of marriage and family therapists and reliance on a convenience sample limit the generalisability of findings. A final limitation, although unavoidable due to the study design, is the simultaneous measurement of training exposure and clinician enquiry behaviour.

With a similar objective, Currier et al. (1996) employed a self-report survey to identify the domestic training experiences and needs of psychiatric residents (N =145). 28% reported to have received domestic violence training, either in medical school, residency or another

source. The findings revealed that increased domestic violence detection in cases was significantly correlated with training in domestic violence and a medium effect size was observed. Additionally, 88% of those who reported to have had received training were significantly more likely to have detected six or more cases of domestic violence within the past year in comparison to just 48% of those who had not received training. A medium effect size was observed between training and case detection when calculated by the authors of this review using phi-coefficients. With regards to the cases of domestic violence detected, clinicians directly asked patients about domestic violence in 43% of cases. No correlation between case detection and clinician gender or length of post-graduate training was observed.

As with Young et al. (2001), findings from Currier et al. (1996) should be interpreted with caution given the study limitations, including the lack of information regarding training content and format, a lack of information regarding the survey development and design as well as simultaneous measurement of training exposure and clinician enquiry behaviour.

Discussion

Review question and interpretation of review findings

The aim of this systematic review was to consider if trauma-related training had a relationship with, or impact on, mental health professionals frequency of asking about, or detection of, trauma history. A second aim was to identify components of training that may be important and make recommendations for future training programmes.

Two-thirds of the studies reported either a statistically significant correlation between trauma-related training and detection of trauma history (Currier et al., 1996), or provided statistically significant evidence to suggest the following; (1) an increase in asking about (Lotzin et al., 2018), (2) more frequent asking about (Murray et al., 2016; Young et al., 2001), and (3) greater detection of trauma histories (Currier et al., 1996; Currier & Briere, 2000;

Sampson & Read, 2017), in mental health professionals who have received trauma-related training. In addition, 35% of mental health professionals in the Donohoe (2010) study reported that they were now asking about abuse history as part of their routine assessment.

Two studies found no significant change in frequency of asking about trauma (Walters et al., 2016) or detection of trauma history, following training (Cavanagh et al., 2004). This is despite the fact that the mean number of clients known to have a trauma history and the mean rate of enquiry about trauma history increased from pre to follow-up in the Walters et al. (2016) study, and that both studies observed statistically significant improvements on other outcomes (e.g. confidence in asking about abuse and responding to disclosures, confidence and knowledge in the assessment and treatment of trauma). Effect sizes ranged from very small to medium. For two studies, the effect sizes could not be calculated due to the inability to retrieve the required data (Cavanagh et al., 2004), and due to the design and analysis (Donohoe, 2010). Overall, this review provides some evidence that trauma-related training is related to, or has an impact on, frequency of asking about, or detection of, trauma history. Despite these encouraging findings, which appear to support the utility of trauma-related training in relation to clinicians frequency of asking about and detection of trauma history, these findings need to be considered in light of the limitations of the studies upon which these findings were based.

The first issue is in relation to the small number of studies included in the review. This is notable, given the resounding recommendations for such training to be delivered over the years. It is unclear whether the lack of studies in the area is reflective of a lack of availability or opportunity for professionals to avail of training, or whether this is due to limited evaluation of training and a lack of dissemination of findings. In a review of training programmes available for health care professionals to facilitate identification of domestic violence, Davidson (2002) concluded that evaluations of such programmes were sparse and

poor in quality. This is problematic, as if good-quality evaluations of training programmes are not conducted, this may impact upon the development of future training programmes, as well as the body of research in the area.

The varying quality of the studies included in the review is also an important consideration when interpreting the findings. Two studies were assigned the "good" category, two studies received the "poor" category and five studies received the "fair" category. Thus, the validity of findings from some of the studies included in the review need to be considered with caution.

Sample size was one of the main areas of concern for most, but not all of the six studies which directly evaluated specific training programmes. Indeed, the failure to detect statistically significant findings in the Cavanagh et al. (2004) and Walters et al. (2016) studies may have been contributed to by small sample size. Issues relating to sample size not only limit the statistical power of studies, but also limit the generalisability of findings and present a threat to the ecological validity of studies. For the three studies which examined trauma-related training experiences more generally, some of the main limitations of these studies were intrinsic to the study design (i.e. limited ability to control for the influence of other variables) and due to the focus of the study (i.e. lacking information regarding professionals training exposure).

With regards to data collection methods, most studies relied on self-report questionnaires to assess clinician enquiry, with two studies using self-report questionnaire to measure both clinician enquiry behaviour and training exposure simultaneously. Therefore, the majority of studies relied on busy mental health professionals to provide recollections of their enquiry behaviour and accounts of their training experiences/exposures and clinical practice, which may not only be distorted by memory and error, but also subject to social desirability bias (Donohoe, 2010; Lotzin et al., 2018; Walters et al., 2016). Furthermore, given that self-report measures were used to evaluate the impact of specific training programmes, this may

have increased the potential risk for expectancy effects (Barker et al., 2010). Similarly, the simultaneous measurement of training experiences and clinician-enquiry and detection behaviour may increase the risk of context effects, whereby participants may alter their responses to further questions in light of preceding questions (Breakwell, Hammond, Fife-Schaw & Smith, 2006).

Alternatives to self-report measures of enquiry or detection behaviour have been suggested in the literature. This has included the use of more objective measures, such as service-related outcomes (i.e. monitoring service level case detection of trauma, the number of trauma-related interventions or referrals made to other services for trauma interventions), as well as client based outcomes (Lotzin et al., 2018; Toner, Daiches & Larkin, 2013)

Recommendations for the designing of future training programmes

The capacity to make recommendations to services or educators regarding future trauma-related programmes is challenging for a number of reasons. Firstly, these recommendations are made on the basis of this review, which as already mentioned, incorporated a small number of studies of varying quality, some of which did not report statistically significant findings. A second issue is that trauma-related training was broadly defined in this review and therefore, training programmes and experiences varied across studies (e.g. source, duration, content). A final challenge to making recommendations for future training programmes is that not all studies in this review collected details regarding professionals' training experiences. Therefore, the recommendations for future training programmes, on the basis of the findings of this systematic review, are tentative.

In professionals own evaluations of their training experiences, professionals typically identified role plays as one of the most useful aspect of their training experience (Cavanagh et al., 2004; Donohoe, 2010; Lotzin et al., 2018). Indeed, while the training in the Walters et

al. (2016) study included case- discussion, problem-solving, as well as information and skill guidance, there was no opportunity for participants to practically apply skills as part of the training. In acknowledgement of the issues relating to sample size and staff restructuring, perhaps the addition of practicing skills through role-play may have improved the efficacy of training and had a statistically significant impact on clinician enquiry behaviour.

In addition to skill based components, Toner, Daiches & Larkin (2013) recommend that participants are given the opportunity to reflect and understand why asking is important, a component which is included in the New Zealand training programme. Other useful aspects of training include a clear structure to the training, an informal style of facilitation (Cavanagh et al., 2004), and the provision of written handouts and summaries (Cavanagh et al., 2004). Psychologists and Psychiatrists in the Young et al. (2001) study recommended that training focuses on the following; (1) how to best enquire about abuse history, (2) enquiry techniques for different groups, (3) effects of child abuse and false allegations of abuse. Finally, consideration should be given to the duration of training programmes, with professionals in the Cavanagh et al. (2004) and Donohoe (2010) requesting more than one day for training and additional follow-up sessions.

Findings in some studies of this review suggested that despite the provision of training, some trauma types were more likely to be asked about or detected than others. Lotzin et al. (2018) observed that the frequency of asking about sexual abuse changed significantly less in both control and intervention groups in comparison to other trauma types. Similarly, Sampson and Read (2017) observed a statistically significant increase in rates of recorded child sexual and physical abuse, adult sexual assault, but no significant increases of recorded rates of adult physical assault were observed. Training programmes and educators should be aware of the potential for variation in professionals frequency of asking about, or detection of, trauma histories across specific trauma types. It may be that some trauma types are more difficult for

professionals to ask about or detect than others and therefore, some may require more specific or additional attention in training.

Educators or services who provide or design training for staff should be aware of the barriers that impact on, or have the potential to impact on, professionals frequency of asking about, or detection of, trauma history as identified over the course of the studies included in this review. Some of these include client or clinician gender (Cavanagh et al., 2004; Currier et al., 2000; Donohoe et al., 2010; Sampson et al., 2017), client or clinician age (Donohoe, 2010; Lotzin et al., 2018), client diagnosis (Cavanagh et al., 2004; Donohoe, 2010; Sampson et al., 2017), fear of inducing false memories, as well as other attitudes and beliefs surrounding trauma history enquiry (Young et al. (2001). These echo findings in the literature (Cunningham et al., 2016; Read et al., 2007; Shannon et al., 2011). Mental health professionals may benefit from education surrounding these barriers and this may be a worthwhile component of training.

It must be acknowledged that detection and recognition of trauma history alone may not be sufficient to ensure appropriate care and treatment and this is an important consideration for training programmes. Eilenberg, Thompson-Fullilove, Goldman and Mellman (1996) found that despite the identification of trauma history, there was evidence of trauma history incorporated into treatment plan and diagnostic assessment in one out of ten charts. It is important that training programmes ensure that clinicians not only identify trauma history, but also use this information in a therapeutic and meaningful way to enhance service user's treatment and outcomes. It is therefore reassuring that responding to disclosures or interventions was included in some of the training programmes included in this review.

Despite the limitations of the studies included in this review, this review provides some evidence to support the utility of trauma-related training in relation to clinician frequency of asking about trauma history and detection of trauma history. However, participation in

trauma-related training needs to be facilitated, encouraged and monitored if it is to be effective.

Following the implementation of a pilot programme in the UK, the Department of Health published a document in 2008 requesting that practitioners routinely ask about violence and abuse histories (physical, sexual and emotional) in all mental health trusts, in addition to attending the designated training to facilitate this (Brooker, Tocque, Kennedy & Brown, 2016). In an evaluation of this policy, Brooker et al. (2016) found that only 66% of staff had received the recommended training. Additionally, there was only evidence in 17% of cases that service users had been asked about a history of sexual/violent abuse in 2014/2015. These results suggest that without monitoring and perseverance from managing and governmental systems, the impact of training and policy will be limited (Read et al., 2018).

Future directions for research and implications for clinical practice

It is clear that more research is needed to determine the relationship between, and the impact of, trauma-related training on mental health clinicians enquiry and detection behaviour in relation to trauma history. Additionally, further research is necessary to determine what such training programmes should comprise. High quality research designs, such as Lotzin et al. (2018), are needed in order to evaluate trauma-related training in a more robust and rigorous manner. Rujne et al. (2017) have published a protocol of a cluster randomised control trial designed to investigate the impact of domestic violence training on mental health professionals' detection of domestic violence. However, with external validity in mind and the need to generalise findings to clinical practice, it is crucial that services that engage or partake in trauma-related training are encouraged to evaluate and disseminate their findings, and are provided with the resources to do so. More objective outcomes of clinician enquiry behaviour are also recommended.

Further research is also needed to ascertain mental health professionals specific training needs and experiences in relation to trauma. For example, in the Currier et al. (1996) study 77% of psychiatric residents felt they would benefit on further training with regards to identification of domestic violence. The identification of specific training needs in relation to trauma, such as the approach adopted in Walters et al. (2016), is important as it allows the development of training programmes directly informed by staff needs.

Whilst acknowledging the limitations of the included studies, this review provides some support regarding the utility of trauma-related training in relation to clinician frequency of asking about, and detection of trauma history. Therefore, mental health professionals may benefit from such training and should be encouraged to engage in trauma-related training. However, as indicated by the Brooker et al. (2016) evaluation, training needs to be encouraged, supported and sustained to derive benefit. It must also be acknowledged that in times of financial crisis and considerable strain on health services, opportunities for services and mental health professionals to obtain training may be more limited. With this in mind, and given the importance of detecting a history of trauma, the use of trauma history measures may be a simple and practical solution to facilitate professionals in asking about, or detecting, trauma history. This is supported by studies by Rossiter et al. (2015) and Shannon et al. (2011), which observed large discrepancies between trauma history detected via trauma history measures in comparison to trauma histories as documented in clinical notes.

Strengths and weakness of the review

This paper provides the first formal and systematic review of the literature examining whether trauma-related training has a relationship with, or impact on, clinicians frequency of asking about, or detection of, trauma history. The strength of this review is its contribution to

not only research in this regard, but also due to the capacity to put forward some recommendations, albeit tentatively, for the development of future training programmes.

As mentioned previously, the broad definition of trauma-related training in this review made it challenging to not only compare findings across studies, but also to make recommendations for the development of future training programmes. With the promise of future studies in the area (e.g. Rujne et al., 2017), it may be possible in the future to conceptualise trauma-related training more definitively.

A final limitation of this review may be in the conceptualisation of "trauma history", which made devising a search strategy in this review a challenge. To the authors knowledge, there exists no readily available definition as to what this should comprise. This is likely explained by the controversy surrounding the definition as to what constitutes a traumatic event (Frueh, Elhai & Kaloupke, 2004), and whether a narrow or more broad definition is more useful (Weathers, Marx, Friedman & Schnurr, 2014). While a broad range of traumatic events were captured by the search strategy of this review, and search terms were similar to that used in a recent review by Read et al. (2018), it is important to acknowledge this a potential limitation of this review, but also to contextualise these definitional issues as part of a wider debate.

Conclusion

Whilst acknowledging the limitations of the evidence presented, this review provides some evidence that trauma-related training is related to, and has an impact on, frequency of asking about, or detection of, trauma history. Very small to medium effect sizes were observed in this regard. Further high quality research is needed. Training programmes should aim to balance skill based and educational components, and consider the potential for variation in clinician enquiry or detection across trauma subtypes, as well as barriers to enquiry.

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Technical Appendices

Appendix A

Subject headings PsychINFO

Subject headings were used in PsychINFO and were combined using “or” with the key words as follows: Training (exp clinical methods training/), Trauma (emotional trauma/ or exp emotional states/ or exp trauma/, Mental Health Professionals (psychiatrists/ or exp mental health personnel/or exp clinicians/or exp psychiatric hospital staff/ or exp psychologist/or exp psychotherapists/), Psychological Assessment (evaluation/ or exp clinical audits/or exp psychiatric evaluation/ or exp intake interview/ or exp psychological assessment).

Appendix B

Quality Assessment tool

Score Key

2 = Well Addressed
1 = Adequately Addressed
0 = Poorly addressed, not addressed, not reported, not applicable

Criteria	Score
1. To what extent was the study question or objectives clearly stated? Did the authors describe their goal in conducting this research? Is it easy to understand what they were looking to find?	
2. To what extent was the study population clearly described and defined? Did the authors describe the group of people from which the study participants were selected or recruited, using demographics, location and time period?	
3. To what extent were issues relating to sample size addressed? Did the authors present their reasons for selecting or recruiting the number of people included or analyzed? Do they note or discuss the statistical power of the study/conduct sample size calculation?	
4. To what extent was the intervention/test/exposure sufficiently defined or described in the study? Duration/timing of intervention, details as to what the intervention involved	
5. To what extent were the tools or methods used to measure the outcomes (dependent variables) clearly defined, pre-specified, accurate and reliable–for example, have they been validated or are they objective?	
6. To what extent was the timeframe sufficient so that one could reasonably expect to see an association between intervention/exposure (i.e training) and outcome if it existed?	
7. To what extent was the following achieved in the discussion section of the study: Summary of key results with reference to study objectives, discuss limitations of the study, taking into account sources of bias or imprecision, discuss both direction and magnitude of any potential bias, give a cautious overall interpretation of results considering objectives, limitations, multiplicity of analyses, results	

from similar studies, and other relevant evidence, discuss the generalisability (external validity) of the study results	
8. To what extent were key potential confounding variables controlled for? Statistical analysis, design, counterbalancing, random sampling/allocation etc	
9. To what extent were statistics and statistical tests described, appropriate and reported? *e.g. effect sizes, tests named, means and SD's provided etc*	

Rater 1 Score Comments	
Rater 2 Score Comments	

Appendix C

Journal formatting requirements of the Journal of Traumatology

This information was extracted from http://www.apa.org/pubs/journals/trm/index.aspx?tab=4.

Manuscript Preparation

Manuscripts submitted to *Traumatology*® should be prepared in accordance with the *Publication Manual of the American Psychological Association*, 6th Edition (2010). Review APA's Checklist for Manuscript Submission before submitting your article.

Formatting

Double-space all copy. Manuscripts should be 30 pages and under (not including references and tables/figures). Other formatting instructions, as well as instructions on preparing tables, figures, references, metrics, and abstracts, appear in the *Manual*. Additional guidance on APA Style is available on the APA Style website.

Below are additional instructions regarding the preparation of display equations, computer code, and tables.

Display Equations

We strongly encourage you to use MathType (third-party software) or Equation Editor 3.0 (built into pre-2007 versions of Word) to construct your equations, rather than the equation support that is built into Word 2007 and Word 2010. Equations composed with the built-in Word 2007/Word 2010 equation support are converted to low-resolution graphics when they enter the production process and must be rekeyed by the typesetter, which may introduce errors.

To construct your equations with MathType or Equation Editor 3.0:

Go to the Text section of the Insert tab and select Object.

Select MathType or Equation Editor 3.0 in the drop-down menu.

If you have an equation that has already been produced using Microsoft Word 2007 or 2010 and you have access to the full version of MathType 6.5 or later, you can convert this equation to MathType by clicking on MathType Insert Equation. Copy the equation from Microsoft Word and paste it into the MathType box. Verify that your equation is correct, click File, and then click Update. Your equation has now been inserted into your Word file as a MathType Equation.

Use Equation Editor 3.0 or MathType only for equations or for formulas that cannot be produced as Word text using the Times or Symbol font.

Computer Code

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We request that runnable source code be included as supplemental material to the article. For more information, visit Supplementing Your Article With Online Material.

In the Text of the Article

If you would like to include code in the text of your published manuscript, please submit a separate file with your code exactly as you want it to appear, using Courier New font with a type size of 8 points. We will make an image of each segment of code in your article that

exceeds 40 characters in length. (Shorter snippets of code that appear in text will be typeset in Courier New and run in with the rest of the text.) If an appendix contains a mix of code and explanatory text, please submit a file that contains the entire appendix, with the code keyed in 8-point Courier New.

Tables

Use Word's Insert Table function when you create tables. Using spaces or tabs in your table will create problems when the table is typeset and may result in errors.

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Abstract and Keywords

All manuscripts must include an abstract containing a maximum of 250 words typed on a separate page. After the abstract, please supply up to five keywords or brief phrases.

References

List references in alphabetical order. Each listed reference should be cited in text, and each text citation should be listed in the References section.

Examples of basic reference formats:

Journal Article:

Hughes, G., Desantis, A., & Waszak, F. (2013). Mechanisms of intentional binding and sensory attenuation: The role of temporal prediction, temporal control, identity prediction, and motor prediction. *Psychological Bulletin, 139,* 133–151. http://dx.doi.org/10.1037/a0028566

Authored Book:

Rogers, T. T., & McClelland, J. L. (2004). *Semantic cognition: A parallel distributed processing approach.*Cambridge, MA: MIT Press.

Chapter in an Edited Book:

Gill, M. J., & Sypher, B. D. (2009). Workplace incivility and organizational trust. In P. Lutgen-Sandvik & B. D. Sypher (Eds.), *Destructive organizational communication: Processes, consequences, and constructive ways of organizing* (pp. 53–73). New York, NY: Taylor & Francis.

Figures

Graphics files are welcome if supplied as Tiff or EPS files. Multipanel figures (i.e., figures with parts labeled a, b, c, d, etc.) should be assembled into one file. The minimum line weight

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A Survey on the Use of Trauma History Measures

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This research was completed by the first author for the qualification of Doctorate in Clinical Psychology. There were no conflicts of interest or financial contributions that could have impacted the results of the study.

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World count: 7,050

Abstract

Objective: Research has highlighted the role of trauma history measures in assessing traumatic exposure, as well as the limitations associated with these measures. With such an array of measures available, the extent to which trauma history measures are used and considered most useful is unknown. Method: An online self-report survey enquiring about the experience of trauma history measures was completed by 528 clinicians, researchers and clinician-researchers working in the field of traumatic stress. Results: Participants identified accessible language and clear presentation as the most important feature of trauma history measures. Trauma history measures appear to be used "often" and "very often" by 56.3% of participants, with evidence suggesting that trauma history measures are used less frequently by clinicians in comparison to clinician-researchers and researchers. Trauma history measures were considered useful in research and clinical practice. Participants reported using measures due to the impact of trauma and its relationship with other presentations, and to provide a comprehensive assessment of trauma. Despite well-known measures (e.g., CTQ; Childhood Trauma Questionnaire) being used by participants in the past year, the majority of participants reported infrequent use of these measures. However, the Life Events Checklist (LEC) and CTQ were identified as the most frequently used measures and were considered most useful. Conclusions: Clinicians should be skilled in assessing trauma history and encouraged, supervised and trained to use trauma history measures when appropriate. Further research is needed to establish a consensus as to the most used and useful trauma history measures in the field.

Keywords: trauma history measures, traumatic exposure, assessing trauma, trauma history, trauma instruments

A Survey on the Use of Trauma History Measures

Research suggests that exposure to traumatic events is relatively common in both clinical and non-clinical populations (Kubany et al., 2000), with rates of traumatic exposure observed to be higher in clinical populations (Cusack, Frueh & Brady, 2004). Cusack et al. (2004) reported that 91% of community mental health service users had been exposed to one or more traumatic life events. High rates of traumatic exposure in clinical samples have also been observed in other studies (Rossiter at al. 2007; Wota et al., 2014).

While traumatic exposure is most commonly linked to the development of PTSD (Bunting, Murphy, O'Neill & Ferry, 2013; Lancaster, Melka and Rodriguez, 2009), the impact of trauma on physical health and mental health has been widely documented (Kendall-Tackett, 2009). Traumatic exposure has been associated with a range of psychological difficulties including psychosis, substance use, depression, anxiety and personality disorders (Cusack et al., 2004). In this regard, trauma presents a significant threat to mental and physical wellbeing, as well as a challenge to public health and services (Frueh, Elhai & Kaloupek, 2004). In addition, where chronic, multiple and/or repeated traumas have occurred, more complex posttraumatic responses are observed (Cloitre et al., 2010).

It is due to the prevalence of trauma and the potentially wide reaching impact on mental health and quality of life (Freuh et al., 2004), that necessitates clinicians to be skilled in conducting routine and comprehensive assessments of trauma (Krinsley, Gallagher, Weathers, Kutter & Kaloupek, 2003). However, a significant body of work has suggested that mental health professionals do not routinely enquire about trauma history (Agar, Read & Bush, 2002; Hepworth & McGowan, 2013; Mitchell, Gatson-Grindel & Laurenzano, 1996; Read, Harper, Tucker & Kennedy, 2018; Shannon, Maguire, Anderson, Meenagh & Mulholland, 2011). Some of the identified barriers to enquiry in this regard include clinician gender; client gender; client age; mental health diagnosis; clinician avoidance of causing distress or

inducing false memories; and limited clinician training in enquiring or responding to disclosures (Cunningham et al., 2016; Read, Hammersley & Rudegeair, 2007; Shannon et al., 2011). Low rates of enquiry may increase the likelihood of traumatic exposure being missed and this is likely to have implications for diagnosis, formulation and treatment, given that spontaneous disclosures to clinicians are unlikely (Cunningham et al., 2016; Mitchell et al., 1996).

Rossiter et al. (2015) and Shannon et al. (2011) observed large discrepancies between trauma histories documented in clinical notes of clients compared to the high levels revealed after administration of trauma history measures. Both studies concluded that trauma history measures offer clinicians and researchers an accurate method of accessing clinically relevant and personally sensitive information in a timely and cost-effective manner.

A large number of trauma history measures are available to clinicians and researchers, with great diversity amongst measures in terms of response format, trauma definitions, as well as time taken to complete measures (Goodman et al., 1998). In addition to a lack of knowledge with regards to how frequently, if at all, trauma history measures are being used, there is also a lack of consensus and guidance as to which trauma history measures are most frequently used and considered most clinically useful in assessing traumatic exposure (Hooper, Stockton, Krupnick & Green, 2011; Weathers & Keane, 2007). This gap in knowledge may make it difficult for clinicians and researchers to identify appropriate measures and may contribute to a lack of consistency in measures being used across studies (Elhai, Gray, Kashdan and Franklin, 2005).

A highly useful online survey of 227 clinicians (predominantly Psychiatrists and Psychologists) was conducted by Elhai et al. (2005), which aimed to identify the most prominent measures used to assess traumatic exposure and posttraumatic symptomatology in clinical and research practice. Clinicians were presented with a list of tests compiled by the

authors and were asked to indicate their frequency of use over the past year in clinical or research activity. The PDS (Posttraumatic Diagnostic Scale), Life Events Checklist (LEC), DAPS (Detailed Assessment of Posttraumatic Stress) and Combat Exposure Scale (CES) were identified as the most commonly used instruments to assess traumatic exposure in clinical practice with adults. With regards to research, the PDS, Conflict Tactics Scale (CTS), LEC, Traumatic Life Events Questionnaire (TLEQ) and CES, were the most frequently used. However, these findings may now be outdated and the utility of these measures was not assessed, information which may further guide clinicians and researchers in selecting appropriate measures and encourage their use. Therefore, the current study aimed to build upon these findings by also ascertaining the utility of trauma history measures, and exploring other important facets of measurement use (e.g. factors that encourage/discourage use, important features of measures), using a large and international sample comprised of a wide range of professionals.

In addition to a lack of understanding regarding the extent of use of trauma history measures and which measures are used and considered most useful, the literature has documented a number of limitations associated with existing trauma history measures (Krinsley et al., 2003; Weathers & Keane, 2007). Burgermeister (2007) reported that many measures have been developed or validated predominantly using psychiatric samples or college samples, with little consideration to socio-economic, educational, ethnic and cultural variance. Burgermeister (2007) refers briefly to the CTQ in this regard, where the original long version was validated using an alcohol dependent sample (Bernstein et al., 1994). In addition, Goodman et al. (1998) and Weathers and Keane (2007) acknowledge a general concern regarding the availability and reporting of psychometric data pertaining to trauma exposure measures, which may limit confidence in selecting and using measures.

With regards to the scope and content of trauma history measures, measures may be restricted to one traumatic event type (e.g. CSA), (Frueh et al., 2004), refer to only one incident of trauma and fail to collect important information such as frequency, duration, age at exposure and the emotional impact of the traumatic exposure (Weathers & Keane, 2007; Widom, Durton, Czaja & DuMont, 2005). In prioritising brevity in this regard, this may limit the capacity of measures to capture details of more complex traumatic exposure.

Given the lack of consensus and guidance as to which trauma history measures are being used and considered most useful in assessing traumatic exposure in clinical and research practice (Hooper et al., 2011), it is important to ascertain the extent to which trauma history measures are being used, as well as to identify and appraise the trauma history measures currently being used by clinicians and researchers. Therefore, the aim of this study was to ascertain, via self-report survey, the important features of trauma history measures, the frequency of use and utility of trauma history measures in clinical and research practice, as well as reasons that encourage and discourage use of trauma history measures. Additionally, the study aimed to identify which specific measures are used and considered most useful, and to compare the frequency and utility of these measures across groups (i.e. clinicians, researchers, clinician-researchers).

Method

Participants

Ethical approval was granted from the Queen's University School of Psychology Ethics committee (Appendix B). An online survey design was utilised and participants were sampled using purposive, convenience and snowballing methodologies. Clinicians and researchers who encounter traumatic presentations in their day-to-day work were eligible for participation. Seven-hundred and twenty-seven individuals accessed the survey available via Qualtrics© software (Qualtrics, 2018). In order to fulfill participants right to withdraw

consent from the study at any time, only data from participants who had completed ≥ 97% of the survey was included in the analysis, leading to a final sample of 528 (See Table 1 and Table 2 for participant characteristics). Participants were predominantly female, aged between 34-49 years and from the USA and UK. Participants with clinical roles were predominantly Clinical Psychologists, specialising in Adult Mental Health. Participants with research roles also predominantly specialised in Adult Mental Health and tended to work in academic settings.

Table 1

Overall Sample Characteristics

Characteristic	Percent	*n*	Characteristic	Percent	*n*
Gender			Country		
Female	67.2	355	USA	40.2	212
Male	32.2	170	UK	26.1	138
Age (34-49 years)	48.5	256	Rep. of Ireland	4.7	25
			Australia	4.0	21
			New Zealand	0.8	4
			“Other”	19.7	104

Table 2

Characteristics of clinical and research roles

Clinical roles	Percent	*n*	Research roles	Percent	*n*
Profession:			Setting:		
Clinical Psychologists	54.7	226	Academic	65.4	227
Specialism:			Specialism:		
Adult Mental Health	57.9	239	Adult mental health	53.3	185
Years of experience			Years of experience		
(6-10 and 16+)	62.0	256	(6-10 and 16+)	60.8	211

Participants were asked to self-select the most appropriate professional group (i.e. clinician, researcher, and clinician-researcher), using definitions adapted from Elhai et al. (2005). This resulted in the composition of three groups; clinicians (n = 181; 34.3%), researchers (n = 115; 21.8%) and clinician-researchers (n = 232; 43.9%).

Chi square analyses was used to investigate differences between these groups (i.e. clinician, researcher and clinician-researcher) and sample characteristics. A significant association between gender and group was observed, where overall, there were more males and less females in the clinician-researcher group, $\chi 2$ (2, N = 525) = 17.51, p > .001, V = 0.18. There was no significant association between group and age. There were also no significant differences between clinicians and clinician-researchers and between researchers and clinician-researchers with regards to years of experience.

Further chi square analyses suggested that clinician-researchers were more likely than clinicians to be clinical psychologists and psychiatrists, and less likely to be nurses, social workers or psychotherapists [$\chi 2$ (7, N = 413) = 48.13, p > .001, V = 0.34]. Clinician-researchers were more likely than clinicians to specialise clinically in adult mental health [$\chi 2$

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$N = 413) = 22.65$, $p = .012$, $V = 0.23$]. In comparison to researchers, clinician-researchers were more likely to conduct research in the area of adult mental health [$\chi 2$ (7, $N = 347$) = 22.22, $p = .002$, $V = 0.25$] and were more likely to conduct their research in a psychiatry or psychology dept. [$\chi 2$ (5, $N = 347$) = 27.69, $p > .001$, $V = 0.28$].

Materials

The areas assessed by the online survey were informed by the aims of the study and included; (1) the most important features of trauma history measures from the perspective of clinicians and researchers, (2) an assessment of the frequency of use and utility of trauma history measures in clinical and research practice, (3) factors that encourage and discourage the use of trauma history measures and (4), the identification of specific measures being used in clinical and research practice.

Survey questions in relation to these areas were constructed in conjunction with the literature and through discussion with the research team, who had clinical and research expertise in the area of trauma, and also by drawing on the guidance from the literature to inform the construction of survey items (e.g. Barker, Pistrang & Elliott, 2010; Breakwell, Hammond, Fife-Schaw & Smith, 2006; Fink, 2009). Question format varied and utilised Likert scale responses (e.g. rating frequency of use of measures on a five point scale ranging from “never” to “very often” and rating the usefulness of measures on a five-point scale ranging from “not at all useful” to “extremely useful”), multiple choice response questions, as well as open-ended questions. This included extension questions such as “other, please specify”, as well as other question formats allowing participants to provide responses not covered by the survey responses and to provide further insights (O’Cathain & Thomas, 2004). Demographic questions were also included. A paper copy of the survey is contained in

Appendix C. This paper version differs in format to the online version presented to participants.

Participants were asked specifically about the utility and frequency of use of the following trauma history measures over the past year: Childhood Trauma Questionnaire (CTQ; Bernstein et al., 1994)/Childhood Trauma Questionnaire Short Form (CTQ-SF; Bernstein et al., 2003), Traumatic Events Questionnaire (TEQ; Vrana & Lauterbach, 1994), as well as the Traumatic Life Events Questionnaire (TLEQ; Kubany et al, 2000), Trauma History Questionnaire (THQ; Green, 1996) and the Life Events Checklist (developed by the National Centre for PTSD). These measures were identified on the basis of the literature, discussion with the research team, as well as a citation index completed using Google Scholar, PsychINFO and Web of Science, which identified these as the most frequently cited measures in the literature.

Procedure

A draft of the survey was initially piloted (word format version) with two clinician-researchers in training. Following amendments, an online version of the survey was piloted by a further eight participants (clinicians, clinician-researchers and researchers), with one participant having particular expertise in the area of trauma (See Appendix D for description of pilot). The final version of the survey was then uploaded online using Qualtrics© software (Qualtrics, 2018).

Participants were contacted via email and received a brief description of the study, as well as a direct link to the survey (See Appendix E). The invitation and survey link was emailed to participants who were identified through PsychINFO as having used either the CTQ, TEQ, THQ, TLEQ or LEC between 2012 and 2017 as part of their research. Additionally, authors of trauma publications who had published in any of the following well

known trauma journals between 2013-2017 were also contacted: Journal of Traumatic Stress, European Journal of Psychotraumatology, Psychological Trauma: Theory, Research, Practice and Policy, Journal of Trauma and Dissociation and the Journal of Interpersonal Violence.

Clinicians and researchers whose contact details were available to the public online were also contacted. This included clinicians and researchers listed as part of trauma networks and projects, clinicians listed under general therapeutic directories and directories for trauma-related therapies (e.g. EMDR, prolonged exposure), trauma centres and clinics, as well as a small number of research/academic departments. Participants were also contacted via email using the combined contacts of the research team, as well as through a professional Twitter account which was set up for the purposes of dissemination. Reminder emails were sent to participants approximately one month following initial contact, where possible. Due to the wide-spread nature of recruitment, it was not possible to calculate a response rate.

Analyses

Quantitative data were analysed using descriptive frequencies and chi square analyses were used to investigate differences between groups (i.e. clinicians, researchers and clinician-researchers), with regards to frequency and utility of trauma history measures. Open ended qualitative data was analysed using content analysis, in line with the protocol outlined by O'Cathain and Thomas (2004). A coding frame was devised and assigned to participants responses and a second coder was used to assess the reliability of codes for two of the open ended questions. Kappa coefficients were .69 and .64 indicating substantial agreement (McHugh, 2012). Discrepancies were discussed and resolved between coders.

Results

Important features of trauma history measures

Participants were asked to rate the importance of a number of features of trauma history using a five-point Likert scale with response options ranging from “not at all important” to “extremely important”. The “very important” and “extremely important” responses pertaining to each feature were totaled to indicate the most important features: clear and accessible language and presentation (87.9%), assesses a range of events and experiences (83.0%), sensitive and non-intrusive (78.5%), provides a comprehensive assessment/measurement of trauma history (76.7 %), assesses features of complex trauma (73.3%), quantitative descriptors of trauma (70.3%), satisfactory psychometric properties (69.7%), a clear and operational definition of trauma (62.7%), and a short completion/administration time (60.4%).

An optional open-ended question invited participants to include additional information on important features of trauma history measures that they considered important. The predominant codes identified in the responses to this question, although provided by a small number of participants, provided additional information to the quantitative findings. Participants expressed a desire for trauma history measures to provide an assessment of symptoms (i.e. PTSD symptoms, dissociation) and/or contextual factors (i.e. family factors, risk) (n = 23). Twenty-one participants identified the need for specific questioning styles and/or formats, such as; (1) question styles that allow for participants to describe their subjective experience (e.g. open ended questions) (n = 9); (2) the need for questions that are behaviorally specific or defined (n = 5) and, (3) “other” types of questions (age/timing of exposure, follow up questions, therapist observations etc.) (n = 7).

Frequency of use and utility of trauma history measures.

Table 3

Percentage frequency of use by group

Group	Never	Seldom	Sometimes	Often	Very often
Clinicians	21.5%(39)	23.8%(43)	21.5%(39)	17.1%(31)	16.0%(29)
Researchers	2.6%(3)	6.1%(7)	22.6%(26)	19.1%(22)	49.6%(57)
Clinician - Researchers	1.7%(4)	9.5%(22)	20.7%(48)	27.2%(63)	40.9%(95)

Participants were asked to indicate their frequency of use of trauma history measures on a five-point Likert Scale with response options ranging from “never” to “very often”. Overall, the majority of participants used trauma history measures in clinical and/or research activity, with 56.3% (n = 297) of participants reporting the use of trauma history measures “often” and “very often”. A significant and moderate association between group (clinician, researcher, clinician-researcher) and frequency of use of trauma history measures was observed, $\chi 2$ (8, N = 528) = 107.26, $p < .001$, Cramer’s $V = .32$. As can be seen in Table 3, 33.1% of clinicians, 68.7% of researchers, and 68.1% of clinician researchers, endorsed that they “often” and “very often” use trauma history measures, suggesting that clinicians are less likely than researchers or clinician-researchers to use such measures. Table 4 illustrates the frequency of responses (“often” and “very often”) from each profession that make up the clinician and clinician-researcher groups.

Table 4

Frequency of use of Trauma History Measures by Clinical Profession (N = 413)

Profession	Often %(n)	Very Often %(n)	Profession	Often %(n)	Very Often %(n)
Clinical Psychologist	18.1(41)	35.8(81)	Other(uncategorised)	12.5(1)	25.0(2)
Counselling Psychologist	25.0(5)	20.0(4)	Other: AP/TCP/ClinicalPhD	0.0(0)	40.0(2)
Counsellor	57.1(4)	0.0(0)	Other: Clinical Neuropsychologists	50.0(1)	0.0(0)
Nurse	25.0(3)	8.3(1)	Other: Neurologist	0.0(0)	100.0(2)
Psychiatrist	33.3(17)	23.5(12)	Other: Combination of Clinical Roles	42.9(3)	14.3(1)
Psychotherapist	28.3(13)	21.7(10)	Other: Forensic Psychologist	0.0(0)	0.0(0)
Social Worker	25.0(6)	37.5(9)			

Clinicians and clinician-researchers (*n* = 413) were asked to consider the utility of trauma history measures in clinical practice on a five-point Likert scale, with response options ranging from “not useful at all” to “extremely useful”. 45% of clinician and clinician-researchers reported finding measures “very useful” and “extremely useful” in clinical practice. 83.9% of researchers and clinician-researchers reported finding measures “very useful” and “extremely useful” in research (Table 5). The five-point Likert scale response options were then collapsed into three response option categories (i.e. “not useful”, “moderately useful”, “very useful”) to facilitate analysis so that differences between groups

Table 5

Utility of measures in clinical practice and research

	Clinical practice		Research	
Rating	Percentage	n	Percentage	n
Not useful at all	1.9	8	0.6	2
Not very useful	9.0	37	1.2	4
Moderately useful	44.1	182	14.4	50
Very useful	30.5	126	46.4	161
Extremely useful	14.5	60	37.5	130

could be explored (e.g. clinicians vs. clinician-researchers and researchers vs. clinician-researchers). No significant differences were observed between clinicians and clinician-researchers [$\chi 2$ (2, N = 413) = 2.92, p = .232, V = .08] or between researchers and clinician-researchers in this regard [$\chi 2$ (2, N = 347) = .63, p = .732, V = .04].

Participants were asked to consider the usefulness of administering or completing trauma history measures with a variety of presentations using a five-point Likert scale with response options ranging from “not useful at all” to “extremely useful”. “Very useful” and “extremely useful” responses were totaled to indicate the utility of administering or completing trauma history measures for each presentation, revealing the following: PTSD/Trauma (83.5%), Complex PTSD/Trauma (81.6%), alcohol/substance use (65.2%), suicidal ideation/self-harm/risk (64.1%), anxiety (60.8%), severe depression (58.3%), eating disorder (56.5%), mild/moderate depression (55.8%), bipolar disorder (50.8%), personality disorder (50.4%), psychosis (48.7%), ADHD (35.5%), intellectual disability (25.4%).

Clinician frequency of asking about trauma history

Clinicians and clinician-researchers were also asked about their frequency of asking client/patients explicitly about trauma history (i.e. not via trauma history measures) as part of routine clinical assessment. The majority of clinicians and clinician-researchers reported asking clients/patients explicitly about trauma history as part of a routine clinical assessment "very often" (n = 266; 64.4%) and "often" (n = 93; 22.5%). There were no significant differences between clinicians and clinician-researchers with regards to frequency of asking about trauma history, $\chi 2$ (2, N = 411) = 2.52, p = .284, V = .08.

Reasons for use or factors that encourage and discourage use of trauma history measures

Participants who reported having used trauma history measures as part of their clinical and/or research activity (n = 482; 91.3%) were asked about their reasons for use of these measures. Participants were asked to select the factor(s) that encouraged their use of measures and the level of endorsement for each factor was calculated to reveal the most important reasons for use. Measures were mainly used by participants due to the relationship with, or impact of, trauma on other presentations and outcomes and to provide a comprehensive assessment of trauma (See Table 6). "Other" responses were provided by a small number of participants (n = 46) and are contained in Appendix I. Overall, responses tended to corroborate with the quantitative responses or response options provided to this question.

Participants were asked to select the factor(s) that discourage the use of trauma history measures in their work and the level of endorsement for each factor was calculated to indicate the most salient factors in this regard. As indicated from Table 7, 53.8% of participants did not identify any factors that discouraged use, given that they use measures as part of their

work. One of the most pertinent factors discouraging use of trauma history measures was the belief that other methods are best to assess trauma history methods (i.e., conversation). "Other" responses were provided by 79 participants and additional information on these responses is contained in Appendix J. Some of the main codes identified from the open-ended data corroborated with the quantitative responses (e.g., trauma history measures not always appropriate or suitable for certain populations/presentations and the use of other methods or approaches), with these responses also reflected in participants responses to the generic open ended question contained in the survey (See Appendix K). Some of the "other" responses also provided additional insights into factors that may discourage the use of trauma history measures, such as the impact of service and/or organisational constraints in using trauma history measures (n = 17).

Table 6

Reasons or factors encouraging use of trauma history measures

Reason	Percentage	n
Trauma is related to and/or the cause of a variety of different clinical presentations/health outcomes which makes it important to identify	80.3	387
To provide a comprehensive assessment/measure of trauma	73.4	354
To elicit clinically relevant information regarding traumatic exposure (e.g. frequency, severity, age at exposure)	69.1	333
To contribute towards the development of formulation and intervention	60.8	293
To facilitate individuals/clients to disclose trauma or aspects of trauma that are difficult to verbalise in a sensitive, non-intrusive manner	37.1	179
Trauma history measures assist in the identification of risk/safeguarding issues	31.1	150
Trauma history measures provide an operational definition of trauma	29.3	141
Trauma history measures have good psychometric properties (i.e. validity and reliability) and thus provide yield valid and reliable information	28.6	138
Other	9.8	47
None of the above	1.3	6

Table 7

Reasons or factors discouraging the use of trauma history measures

Reason	Percentage	n
None. I use trauma history measures as part of my clinical and/or research activity	53.8	284
Trauma history is best assessed using other methods (e.g. conversation)	19.3	102
Other	15.3	81
Trauma history measures do not adequately define trauma (e.g. inclusion/exclusion of certain traumatic events)	13.5	71
Trauma history measures are intrusive and impersonal	12.3	65
I have limited resources/access to trauma history measures	11.7	62
Trauma history measures are not relevant to the population/sample I work with	3.8	20
I am unsure what trauma history measures to use	7.4	39
Trauma history measures have unsatisfactory psychometric properties (e.g. validity, reliability)	7.2	38
I lack confidence/skills in using trauma history measures	5.9	31

Specific measures used in clinical and research practice

Frequency of use of specific trauma history measures in clinical and research practice.

Participants were asked to indicate the frequency of use of the CTQ, THQ, TLEQ, TEQ and LEC over the past year using a five-point Likert scale with responses ranging from "never" to "very often". Table 8 displays the frequency of use of each of these measures.

Table 8

Percentage frequency of use of the LEC, CTQ, TLEQ, TEQ and THQ over the past year

Measure	Never	Seldom	Sometimes	Often	Very often
LEC	54.2%(286)	8.7%(46)	11.2%(59)	11.6%(61)	14.4%(76)
CTQ	57.8%(305)	11.7%(62)	13.3%(70)	7.6%(40)	9.7%(51)
TLEQ	71.8%(379)	8.1%(43)	8.9%(47)	5.7%(30)	5.5%(29)
TEQ	72.0%(380)	11.6%(61)	10.0%(53)	3.2%(17)	3.2%(17)
THQ	73.9%(390)	10.0%(53)	10.2%(54)	3.6%(19)	2.3%(12)

While investigation of the "seldom", "sometimes", "often" and "very often" categories suggest that each of these measures have been used over the past year, the majority of participants reported to have "never" used these measures over the past year (54.2% - 73.9%). The LEC and CTQ were the measures most frequently used "often" and "very often" by a total of 26.0% and 17.3% of participants respectively, over the past year.

Individual analyses were completed comparing the three professional groups on how frequently they used each measure. There was a significant association between professional group and frequency of use on the CTQ [$\chi 2$ (8, N = 528) = 44.64, p < .001], TEQ [$\chi 2$ (8, N =

528) = 22.52, p = .004], THQ [$\chi 2$ (8, N = 528) = 28.47, p < .001], TLEQ [$\chi 2$ (8, N = 528) = 35.76, p < .001] and LEC [$\chi 2$ (8, N = 528) = 46.73, p <. 001] (Appendix L). Associations were moderate for the CTQ (V = .21) and LEC (V = .21) but weak for the remaining measures [TEQ (V = .15), THQ (V= .16), TLEQ (V= .18)]. Results indicated that clinician-researchers and researchers used these measures more frequently than clinicians, with clinician-researchers reporting most frequent use of all measures. The only exception to this was the CTQ, which appeared to be used more frequently by researchers.

48.3% (n = 255) of participants acknowledged the use of other trauma history measures. 94.9% (n = 242) of these participants (representing 45.8% of the full sample), provided the name of at least one measure used to assess trauma history, resulting in a list of ninety-three different measures used to assess traumatic exposure. This excluded fourteen responses provided by participants in which it was not possible to identify the measure and seven responses, which were not measures/instruments.

The following were the top five most reported measures used by participants, where the percentage of participants indicating use of the measure was calculated out of the total sample (N = 528); Impact of Events Scale/Impact of Events Scale Revised (IES/IES-R; n = 29; 5.5%), the Adverse Childhood Experience questionnaire (ACE; n = 27; 5.1%), PTSD Checklist (PCL; n = 21; 4.0%), Posttraumatic Diagnostic Scale (PDS; n = 21; 4.0%), and the Clinician Administered PTSD Scale (CAPS; n = 17; 3.2%). “Often” and “very often” response categories were totaled to provide an indication of the frequency of use of each of these measures over the past year: PCL (90.5%), ACE (77.8%), PDS (66.6%), CAPS (64.7%) and the IES (58.6%) (See Table 9). The PCL appeared to be used most often.

Table 9

Frequency of use of PCL, ACE, PDS, CAPS and IES/IES-R over the past year

Measure	Never	Seldom	Sometimes	Often	Very often	Missing	Total
PCL	0%(0)	0%(0)	4.8%(1)	28.6%(6)	61.9%(13)	4.8%(1)	100%(21)
ACE	0%(0)	0%(0)	22.2%(6)	37.0%(10)	40.8%(11)	0%(0)	100%(27)
PDS	0%(0)	4.8%(1)	28.6%(6)	14.3%(3)	52.3%(11)	0%(0)	100%(21)
CAPS	5.9%(1)	0%(0)	29.4%(5)	29.4%(5)	35.3%(6)	0%(0)	100%(17)
IES/IER	0%(0)	6.9%(2)	24.1%(7)	13.8%(4)	44.8%(13)	10.5%(3)	100%(29)

Utility of specific measures used in clinical and research practice.

Participants who indicated having used the CTQ, TEQ, THQ, TLEQ and LEC over the past year were asked to comment on the usefulness of these measures using a five point Likert scale, with response options ranging from “not useful at all” to “extremely useful”. As indicated by Table 10, the CTQ and LEC appeared to be the most useful. A total of 54.2% and 53.7% of participants regarded the CTQ and LEC respectively, as “very useful” and “extremely useful”.

Individual analyses were completed comparing the three professional groups on the utility of each measure. The five-point Likert scale response options were collapsed to produce three response option categories (“not useful”, “moderately useful” and “very useful”) to facilitate analysis. There was no significant association between professional group and utility on the TEQ [$\chi 2$ (4, N = 148) = 4.07, p = .397, V = 0.12], THQ [$\chi 2$ (4, N = 138) = 2.18, p = .703, V = 0.09], TLEQ [$\chi 2$ (4, N = 149) = 3.80, p =.434, V = 0.11] and LEC [$\chi 2$ (4, N = 242) = 7.89, p = .096, V = 0.13]. Results suggest that these measures were predominantly regarded as “moderately useful” and “very useful” across all groups (Appendix M). However, a weak, but significant, association was observed between group

and the CTQ [$\chi 2$ (4, $N = 223$) = 14.18, $p = .007$, $V = 0.19$]. Clinicians were more likely than researchers and clinician-researchers to regard the CTQ as "moderately useful" and less likely than these groups to regard the CTQ as "very useful".

Table 10

Usefulness of the CTQ, LEC, THQ, TEQ and TLEQ

Measure	Not useful at all	Not very useful	Moderately useful	Very useful	Extremely useful
CTQ	1.8%(4)	3.6%(8)	40.4%(90)	43.0%(96)	11.2%(25)
LEC	0%(0)	4.1%(10)	42.2%(102)	37.6%(91)	16.1%(39)
THQ	2.2%(3)	7.2%(10)	51.4%(71)	34.1%(47)	5.1%(7)
TEQ	2.0%(3)	7.4%(11)	56.8%(84)	28.4%(42)	5.4%(8)
TLEQ	0%(0)	3.4%(5)	48.3%(72)	37.6%(56)	10.7%(16)

Participants who had reported use of the IES/IES-R, ACE, PCL, PDS and CAPS (identified as the top five additional measures used by participants) were asked to rate the utility of these measures. "Very useful" and "Extremely useful" categories were totaled to provide an indication of the utility of each measure: CAPS (82.3%), ACE (77.7%), PDS (76.2%), PCL (71.4%) and IES (41.4%). (See Table 11). The CAPS appeared to be considered the most useful.

Table 11

Usefulness of the CAPS, ACE, PDS, PCL and IES/IES-R

Measure	Not useful at all	Not very useful	Moderately useful	Very useful	Extremely useful	Missing	Total
CAPS	0%(0)	0%(0)	5.9%(1)	29.4%(5)	52.9%(9)	11.8%(2)	17(100%)
ACE	0%(0)	0%(0)	18.5%(5)	44.4%(12)	33.3%(9)	3.7%(1)	100%(27)
PDS	0%(0)	0%(0)	23.8%(5)	47.6%(10)	28.6%(6)	0%(0)	100%(21)
PCL	1(4.8%)	0%(0)	14.3%(3)	38.1%(8)	33.3%(7)	9.5%(2)	100%(21)
IES/IES-R	0%(0)	3.4%(1)	37.9%(11)	20.7%(6)	20.7%(6)	17.2%(5)	100%(29)

Discussion

The aim of this study was to identify important features of trauma history measures, the frequency and utility of trauma history measures in clinical and research practice, as well as reasons that encourage and discourage use of trauma history measures. Additionally, the study aimed to identify the specific measures used and considered most useful in clinical and research practice, and to compare the frequency and utility of these measures across groups (i.e. clinicians, researchers, clinician-researchers).

Clear language and presentation is an important feature of trauma history measures. Overall, trauma history measures were used less frequently by clinicians and more frequently by clinician-researchers and researchers. Additionally, trauma history measures were regarded as useful in clinical and research practice. Encouraging use of measures was the acknowledgement of the impact of trauma and its relationship with other presentations, as well as the need to provide a comprehensive assessment of trauma. The belief that trauma is best assessed using other methods was regarded as the main factor discouraging use. The LEC and CTQ were the most frequently used and considered most useful.

The need for measures with clear and accessible language and presentation is important. While accessibility of trauma history measures, in terms of language and presentation, appears to have received no attention in the literature, this has become a topic of interest in relation to health. Paz, Liu, Fongwa, Morales and Hays (2009) discovered that many health-related quality of life surveys contained items that required levels of reading that may exceed the reading levels of the general population. As complex language and poor presentation may lead to confusion and inaccuracies in responding, this is an area worthy of further attention with regards to trauma history measures.

With regards to the frequency of use of trauma history measures, overall, trauma history measures were used “often” and “very often” by 56% of participants. The finding that

participants reported using measures due to the impact of trauma and its relationship with other presentations, and to provide a comprehensive assessment of trauma, is reassuring. This indicates an awareness of both the complexities of trauma with regards to co-morbidity and the need for comprehensive assessment (Frueh et al., 2004; Krinsley et al., 2003).

The finding that trauma history measures were used more frequently by clinician-researchers and researchers, and less frequently by clinicians is a new and important finding which requires exploration. Less frequent use of trauma history measures by clinicians may be explained by the professional composition of these groups. The clinician group in this study was comprised of less clinical psychologists and psychiatrists than the clinician-researcher group, but more nurses, social workers and psychotherapists. It may be that while these professionals, particularly nurses and social workers, work with clients with traumatic presentations, they may be less likely to conduct formal trauma assessments, and thus, use trauma history measures less by proxy of their profession or role.

The finding that measures were regarded as "extremely useful" in research (by researchers and clinician-researchers), but only "very useful" in clinical practice (by clinicians and clinician-researchers), appeared initially to provide an alternative or additional explanation for the less frequent use of measures by clinicians. However, this is not sufficient evidence to conclude that measures are considered less useful in clinical practice, given that there were no significant differences between clinicians and clinician-researchers regarding the utility of trauma history measures in clinical practice. While it is an important and useful finding that trauma history measures are regarded as useful in both contexts, a discrepancy with regards to the utility of measures between clinical and research practice would not have been unusual, given that many measures originated and were developed for research use (Hooper et al., 2011). However, it was not possible in the current study to directly compare all three groups (clinicians, clinician-researchers and researchers) regarding the utility of measures in clinical

vs. research practice due to the format in which this question was presented. Additionally, the survey did not assess for any differences with regards to the frequency of use or utility of measures between clinical and research practice in those who use measures in both clinical and research contexts (i.e. clinician researchers). Given that "clinical scientists" (research and science focus) were found to engage in higher test use for research purposes than "scientist-practitioners" (clinical practice and research) and "practitioner scholars" (clinical practice only) in the Elhai et al. (2005, pp. 544) study, investigation of this may have allowed greater comparisons between the two studies. This may be a useful consideration for future studies.

The belief that trauma is best assessed using other methods, which was revealed through the quantitative and qualitative data, may explain why 44% of participants in the current study were not using trauma history measures often, and may also explain the lower rates of use in clinicians. Indeed, a large number of clinicians and clinician-researchers in the current study (87%) reported asking patients/clients explicitly about trauma "often" and "very often", a finding that is contrary to a large volume of research suggesting low rates of enquiry (Read et al., 2007). However, as clinicians and clinician-researchers did not differ significantly with regards to frequency of asking, this is unlikely to explain the lower frequency of use of measures in clinicians. It must also be acknowledged that participants in this study were largely selected because of their work with traumatised individuals and this may have contributed to the higher than expected rates of enquiry.

With regards to more specific measure use, while self-reported use of the CTQ, THQ, TEQ, TLEQ and the LEC were infrequent over the past year, the LEC and CTQ were the most frequently used and were regarded the most useful of these measures. The LEC was most frequently used by clinician-researchers and researchers, while the CTQ appeared to be most frequently used by researchers. Although there was no significant differences between groups regarding the utility of measures (including the LEC), the CTQ was considered less useful by

clinicians. This finding implies that the CTQ may be regarded as more suited to research than clinical practice.

In comparing findings with the Elhai et al. (2005) study, the LEC was the second most popular measure to assess trauma history in adults for clinical and research purposes. The popularity of the LEC may be explained by its satisfactory psychometric properties (Gray, Litz, Hsu & Lombardo, 2004) and due to its ease of accessibility for clinicians and researchers (Elhai et al., 2005). Use of the CTQ did not appear to be queried in the Elhai et al. (2005) study. However, this measure has also been shown to have good psychometric properties (Bernstein et al., 1994; Bernstein et al., 2004). Support for these measures has also been obtained elsewhere (see Elhai, Ford & Nefiah, 2010).

The most frequently suggested measures volunteered by participants included the IES/IES-R, ACE, PCL, PDS and the CAPS. The PCL was used most frequently and the CAPS was regarded as the most useful. The PDS, IES/IES-R, PCL, CAPS were identified as frequently used posttraumatic symptom measures in the Elhai et al. (2005) study, with the PDS identified also as the most frequently used traumatic exposure measure. Whilst acknowledging the small number of participants in the study who volunteered these measures, the use of these measures to assess traumatic exposure is interesting, given that these measures tend to be regarded as posttraumatic symptoms measures or diagnostic measures (Frueh et al., 2004). This seems to be in fitting with the small number of participants (n = 23), who through the open-ended data, expressed a desire for trauma history measures to provide an assessment of symptoms as well as other contextual factors (i.e. family factors, risk) when asked about important features of trauma.

Implications of findings for practice and recommendations for future research

The findings of this study may guide clinicians and researchers in selecting trauma history measures and encourage their use. With just over 56% of the overall sample using trauma history measures often and less frequent use reported by clinicians, further research is needed to identify how clinicians who work with trauma are assessing or screening trauma if trauma history measures are not used routinely. This is particularly important, given that in contrast to the findings of this study, research has documented low rates of enquiry by mental health professionals (Agar, Read & Bush, 2002; Cunnigham et al., 2016; Hepworth & McGowan, 2013).

Despite their limitations, the utility of trauma history measures is supported by the literature (Rossiter et al., 2015; Shannon et al., 2011) and their utility has been further supported by the findings of this study. With this, and the development of trauma-informed services in mind (Sweeney, Clement, Filson & Kennedy, 2016), it is imperative that all clinicians, particularly those in mental health services, are skilled in detecting or screening for trauma and where appropriate, are trained, supervised and encouraged to use trauma history measures. Furthermore, clinicians who formally conduct trauma assessments should be encouraged to use trauma history measures following sensitive enquiry about history of exposure, and choose instruments with good psychometrics that offer coverage of a broad range of traumatic events (Elhai et al., 2010). Additionally, clinicians and researchers should prioritise measures with clear language and presentation and an assessment of the readability of existing trauma history measures is recommended as an area for future research. While further research is required in order to establish a consensus with regards to the most frequently used and useful measures in the field, this study provides some support for the LEC and the CTQ.

Strengths and limitations

In acknowledging the value and contribution of the Elhai et al. (2005) study, this is the first study to ascertain both the extent of use and the utility of trauma history measures from the perspective of clinicians and researchers who work in the field of trauma. The study is further strengthened by the recruitment of a large international sample size. While the use of an online platform facilitated this large sample size, self-reported test use may be inaccurate (Elhai et al., 2005) and responses may have been susceptible to social desirability. The anonymous nature of the study may have minimized social desirable responding. Additionally, snowballing and convenience sampling methodologies may have increased susceptibility to self-selection bias and thus, skewed the results of the study.

As the survey was designed by the research team, the survey was susceptible to the teams own bias regarding their own experience and use of trauma history measures. However, this threat was minimized by the piloting and review process.

Conclusions

Trauma history measures were used frequently by just over half of participants, but less so by clinicians. The LEC and CTQ were identified as the most frequently used and considered most useful. However, further research is needed to establish a consensus as to the most used and useful trauma history measures in the field. It is recommended that clinicians in mental health services are skilled in assessing trauma history and encouraged, supervised and trained to use trauma history measures when appropriate. Clear language and presentation is an important feature of trauma history measures. Additionally, trauma history measures that cover a broad range of events with satisfactory psychometric properties should be used as part of the formal trauma assessment procedure (Elhai et al., 2010).

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Technical Appendices

Appendix A

Table 1

Additional participant demographics

Demographic	Percentage	n
Age		
18-33 years	22.3	118
34-49 years	48.5	256
50-65 years	23.1	122
65+	6.1	32
Gender		
Female	67.2	355
Male	32.2	170
Missing	0.6	3
Clinicians		
Years as a clinician		
0-5 years	19.6	81
6-10 years	23.7	98
11-15 years	18.4	76
16+	38.3	158
Clinical profession		
Clinical Psychologist	54.7	226
Counselling Psychologist	4.8	20
Counsellor	1.7	7
Nurse	2.9	12
Psychiatrist	12.3	51
Psychotherapist	11.1	46
Social Worker	5.8	24
Other: AP/TCP/Clinical Psychology PHD students	1.2	5
Other: Clinical Neuropsychologists	0.5	2
Other: Neurologist	0.5	2
Other: Combination of Clinical Roles	1.7	7

Demographic	Percentage	n
Other: Forensic Psychologist	0.7	3
Uncategorised Other	1.9	8
Clinical specialism		
Adult mental health	57.9	239
Addiction	2.7	11
Child and Adolescent Mental Health Services	13.3	55
Forensics	3.6	15
Health	4.1	17
Intellectual Disability	1.2	5
Neuropsychology	1.2	5
Older Adults	1.0	4
Paediatrics	1.2	5
Psychosis	2.4	10
Other: Children, Adolescents, and Families	3.1	13
Other: Trauma/PTSD (generic & specific areas)	5.3	22
Uncategorised Other	2.9	12
Theoretical orientation		
Behavioural	3.9	16
Cognitive	2.2	9
Cognitive Behavioural	42.1	174
Medical Model	6.8	28
Psychodynamic/Psychoanalytic	14.5	60
Systemic/Family Therapy	9.7	40
Other: Trauma Focused approaches (e.g EMDR, AIP)	2.9	12
Other: Integrative/Combination of models	8.7	36
Other: Third Wave Approaches (DBT, ACT, CFT etc)	1.7	7
Other: Humanist approach/Client centred	3.1	13
Uncategorised Other	3.4	18

Demographic	Percentage	n
Years as a researcher		
0-5 years	20.7	72
6-10 years	30.8	107
11-15 years	18.4	64
16+	30.0	104
Research specialism		
Adult Mental Health	53.3	185
Addiction	3.2	11
Children, young people and families	17.6	61
Education	0.6	2
Forensic	5.8	20
Health	4.9	17
Neuro/psychobiology	5.2	18
Other: Violence	1.4	5
Other: Veterans/ Millitary	1.4	5
Other: Trauma/PTSD (generic or specific focus)	3.7	13
Uncategorised Other (please specify)	2.9	10
Research setting		
Academic (e.g. university)	65.4	227
Counselling service/MH service	1.2	4
Psychiatry dept.	9.8	34
Psychology service	12.7	44
Social Work service	0.9	3
Other: Military/Veteran Affairs Dept or organisation	1.4	5
Other: Hospital/Health Setting	2.3	8
Other: Governmental Agencies/Dept	2.0	7
Other: Charity	0.9	3
Uncategorised Other	2.3	12

Appendix B

Ethics

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30 August 2017
Ms Lisa Coyle
C/o School of Psychology

Dear Lisa

Full title of Study: An Evaluation of Trauma History Measures.
PREC reference number: No 02-2017-18

Thank you for your response to our request for further information regarding the above mentioned research application.

I can confirm that ethical approval has been granted for your project by the School of Psychology Research Ethics Committee, on behalf of Queen's University Belfast.
Please note that the Participant Information sheet should include an appended statement confirming ethical approval.

It is the responsibility of the Chief Investigator to ensure that the research has been recorded on the University's Human Subjects Research Database otherwise it will not be covered by the University's indemnity insurance. This database can be found in the 'My Research' section of Queen's On-line.

Yours sincerely

Dr Eugene O'Hare (Chair)
Psychology Research Ethics Committee
Cc Dr D Hanna

Appendix C

Copy of Survey

An Evaluation of Trauma History Measures

Thank you for your interest in this study. My name is Lisa Coyle and I am a final year Doctorate in Clinical Psychology student.

What is this study about?

This information sheet provides details of a research study being carried out by the School of Psychology at Queen's University Belfast and has ethical approval from the university. The purpose of the study is to evaluate the usefulness of trauma history measures. We are specifically interested in the view of clinicians who are likely to encounter traumatic presentations in their day-to-day clinical practice and also researchers who work within the field of trauma.

What will participation involve?

Participation in this study will involve completing this online survey. The survey will take approximately 10 minutes to complete. Your participation in this study is completely voluntary. You can stop completing the survey at any time and your data will be discarded. However, once you have submitted the survey, it will not be possible to withdraw the data as no identifying information is collected.

Will the information I give be confidential?

You will not be required to provide personally identifying information in this survey. All information will be treated confidentially. Please note that we may wish to include quotes obtained from the survey in the write up of this research. However, quotes that may be personally identifiable will not be included. Survey data are currently stored on Qualtrics which is accessible by the research team by secure password. The survey data will be exported into SPSS for analysis and stored on a password protected computer.

Are there any risk involved in taking part in the research?

We do not expect that there will be any risks related to taking part in this study. However, if completing the survey raises any issues for you, you will be able to contact the research team on the provided email address.

After I complete the survey, what happens next?

The survey data will be exported for analysis on a password protected laptop. Only the research team will have access to this information. The final results and report will be submitted to Queen's University Belfast as part of the Doctorate in Clinical Psychology programme and also to a peer-reviewed journal and may be presented where opportunities arise. You request a copy of the journal article from a member of the research team via email, in the event that the research is published.

Who can I contact for further information or queries? You can contact the research team on the following email address: lcoyle20@qub.ac.uk or donncha.hanna@qub.ac.uk.

By ticking "yes" below, you confirm that you have read and understood the information provided and agree to participate in this study.

- ☐ Yes (1)
- ☐ No (2)

Q2. Section 1

In this section, you will be asked questions in relation to your occupation

First, we need to identify your occupation using the definitions (adapted from Elhai et al., 2005) presented below:

Clinician

By "clinician" we refer to a clinical practitioner whose role involves direct clinical care of patients/ clients.

Researcher

By "researcher", we refer to a professional involved in the collection, collation and analyses of data in response to specific research questions for presentation, publication or dissemination.

Clinician-Researcher

By "clinician/researcher", we refer to a professional whose role involves BOTH direct clinical care of patients/clients and the collection, collation and analyses of data in response to specific research questions for presentation, publication or dissemination.

With these definitions in mind, which of the following best describes your main occupation?

- Clinician (1)
- Researcher (2)
- I am a Clinician-Researcher (3)

Q3. **How many years (in total) have you been a Clinician?**

(*Clinicians and Clinician-Researchers only)

- □ 0 – 5 years (1)
- □ 6 – 10 years (2)
- □ 11 – 15 years (3)
- □ 16+ years (4)

Q4. How many years (in total) have you been a Researcher?

(*Researchers and Clinician-Researchers only)

- □ 0-5 years (1)
- □ 6-10 years (2)
- □ 11-15 years (3)
- □ 16+ (4)

Q5. **Which of the following best describes your clinical profession?**

(*Clinicians and Clinician-Researchers only)

- □ Clinical Psychologist (1)
- □ Counselling Psychologist (2)
- □ Counsellor (3)
- □ Nurse (4)
- □ Psychiatrist (5)
- □ Psychotherapist (6)
- □ Social Worker (7)
- □ Other (please specify) (8)

_____

Q6. **Which of the following best describes your clinical specialism?**

(*Clinicians and Clinician-Researchers only)

- Adult mental health (1)
- Addiction (2)
- Child and Adolescent Mental Health Services (3)
- Forensics (4)
- Health (5)
- Intellectual Disability (6)
- Neuropsychology (7)
- Older Adults (8)
- Paediatrics (9)
- Psychosis (10)
- Other (please specify) (11)

_____

Q7. **Which of the following best describes your primary theoretical orientation?**

(*Clinicians and Clinician-Researchers only)

- Behavioural (1)
- Cognitive (2)
- Cognitive Behavioural (3)
- Medical Model (4)
- Psychodynamic (5)
- Systemic (6)
- Other (please specify) (7)

_____

Q8. Which of the following best describes the clinical population or area that is the primary focus of your research?

(*Researchers and Clinician-Researchers only)

- ☐ Adult Mental Health (1)
- ☐ Addiction (2)
- ☐ Children, young people and families (3)
- ☐ Education (4)
- ☐ Forensic (5)
- ☐ Health (6)
- ☐ Intellectual Disability (7)
- ☐ Neuro/psychobiology (8)
- ☐ Other (please specify) (9)

_____

Q9. Which of the following best describes your research setting?

(*Researchers and Clinician-Researchers only)

- ☐ Academic (e.g. university) (1)
- ☐ Counselling service (2)
- ☐ Psychiatry dept. (3)
- ☐ Psychology service (4)
- ☐ Social Work service (5)
- ☐ Other (please specify) (6)

_____

Q10. ***Section 2:***

This section asks you questions regarding your use of trauma history measures

Trauma history measures are self-report or clinician administered instruments designed to assess exposure or potential exposure of an individual to traumatic events. Trauma history measures assess a number of details regarding exposure to traumatic events (e.g. frequency, type of traumatic event). In this survey we are interested in your experiences with measures of trauma *history* (e.g., type of traumatic event, frequency of traumatic events) as described above rather than measures of trauma/PTSD *symptoms* (e.g., re-experiencing, avoidance, hyper-arousal). There are many trauma history measures available. Some examples of trauma history measures include the Childhood Trauma Questionnaire, the Trauma History Questionnaire, the Traumatic Events Questionnaire, the Trauma Life Events Questionnaire and the Life Events Checklist.

How often do you use trauma history measures in your clinical and/or research activity?

- Never* (1)
- Seldom (2)
- Sometimes (3)
- Often (4)
- Very often (5)

*Participant is automatically directed to Q12 if responses is “never”

Q11. Why do you use trauma history measures as part of your clinical and/or research activity? Please tick all that apply

☐ Trauma is related to and/or the cause of a variety of different clinical presentations/health outcomes which makes it important to identify (1)

☐ To provide a comprehensive assessment/measure of trauma (2)

☐ To elicit clinically relevant information regarding traumatic exposure (e.g. frequency, severity, age at exposure) (3)

☐ To contribute towards the development of formulation and intervention (4)

☐ To facilitate individuals/clients to disclose trauma or aspects of trauma that are difficult to verbalise in a sensitive, non-intrusive manner (5)

☐ Trauma history measures have good psychometric properties (i.e. validity and reliability) and thus provide yield valid and reliable information (6)

☐ Trauma history measures provide an operational definition of trauma (7)

☐ Trauma history measures assist in the identification of risk/safeguarding issues (8)

☐ None of the above (9)

☐ Other: Please describe your reasons (other than those listed above) for using trauma history measures in your clinical and/or research activity (10)

_____

Q12. What reasons or factors, if any, discourage you from using trauma history measures in your clinical and/or research activity? Please tick all that apply

☐ Trauma history measures are not relevant to the population/sample I work with (1)

☐ Trauma history is best assessed using other methods (e.g. conversation) (2)

☐ Trauma history measures are intrusive and impersonal (3)

☐ Trauma history measures have unsatisfactory psychometric properties (e.g. validity, reliability) (4)

☐ Trauma history measures do not adequately define trauma (e.g. inclusion/exclusion of certain traumatic events) (5)

☐ I lack confidence/skills in using trauma history measures (6)

☐ I have limited resources/access to trauma history measures (7)

☐ I am unsure what trauma history measures to use (8)

☐ None. I use trauma history measures as part of my clinical and/or research activity (9)

☐ Other: Please describe other reasons or factors (other than those listed above) that discourage the use of trauma history measures in your clinical and/or research activity. (10) _____

Q13. How useful are trauma history measures in clinical practice?

(*Clinicians and Clinician-Researchers only)

- not useful at all (1)
- not very useful (2)
- moderately useful (3)
- very useful (4)
- extremely useful (5)

Q14. How useful are trauma history measures in research?

(*Researchers and Clinician-Researchers only)

- not useful at all (1)
- not very useful (2)
- moderately useful (3)
- very useful (4)
- extremely useful (5)

Q15. Please indicate how useful you consider administering or completing trauma history measures with the populations and presentations listed below.

Presentation	Not useful at all	Not very useful	Moderately useful	Very useful	Extremely useful
Adults (1)	☐	☐	☐	☐	☐
Older adults (65+) (2)	☐	☐	☐	☐	☐
Children (3)	☐	☐	☐	☐	☐
Adolescents (4)	☐	☐	☐	☐	☐
Males (5)	☐	☐	☐	☐	☐
Females (6)	☐	☐	☐	☐	☐
Depression (mild/moderate) (7)	☐	☐	☐	☐	☐
Severe Depression (8)	☐	☐	☐	☐	☐
Anxiety Disorder (e.g. GAD, OCD) (9)	☐	☐	☐	☐	☐
Psychosis (10)	☐	☐	☐	☐	☐
Alcohol/Substance misuse (11)	☐	☐	☐	☐	☐
Bipolar Disorder (12)	☐	☐	☐	☐	☐
PTSD/Trauma (13)	☐	☐	☐	☐	☐
Complex PTSD (14)	☐	☐	☐	☐	☐

Suicidal Ideation/Self-harm/Risk (15)	□	□	□	□	□
ADHD (16)	□	□	□	□	□
Personality Disorder (17)	□	□	□	□	□
Eating Disorders (18)	□	□	□	□	□
Intellectual Disability (19)	□	□	□	□	□

Q16. We would like to know more about the features of trauma history measures that you are consider to be important. Read each statement carefully. Indicate how you feel about each statement using the rating scale.

Feature	Not important at all (1)	Not very important (2)	Moderately important (3)	Very important (4)	Extremely important (5)
Provides a comprehensive assessment/measurement of trauma history (i.e. history, severity, impact, frequency, typology) (1)	☐	☐	☐	☐	☐
Satisfactory psychometric properties (e.g. validity and reliability) (2)	☐	☐	☐	☐	☐
Assesses a range of traumatic events and experiences (3)	☐	☐	☐	☐	☐
Assess features of complex trauma (i.e. a unique history of prolonged, repeated traumatic events in order to discriminate from circumscribed trauma history (i.e. “simple”, one off trauma) (4)	☐	☐	☐	☐	☐
Includes quantitative descriptors of trauma (e.g. severity, frequency, age, impact) (5)	☐	☐	☐	☐	☐
Has a clear and operationalised definition of trauma (6)	☐	☐	☐	☐	☐
Elicits information in a sensitive and non-intrusive manner (7)	☐	☐	☐	☐	☐
Uses clear and accessible language and is presented clearly (8)	☐	☐	☐	☐	☐

Short administration/completion time (9)	□	□	□	□	□

Q17. **Please use this box to include other features of trauma history measures not included above that you feel are important (optional)**

_____

_____

_____

_____

_____

Q18. ***Section 3:***

This section asks about your use of specific trauma history measures

Childhood Trauma Questionnaire (CTQ): The Childhood Trauma Questionnaire (Bernstein et al., 1994; Bernstein et al., 2003), available in both long and short forms, measures childhood trauma history. The scale contains five subscales: emotional abuse, sexual abuse, physical abuse, emotional neglect and physical neglect.

In the past year, how often have you used this measure*?

- Never (1)
- Seldom (2)
- Sometimes (3)
- Often (4)
- Very often (5)

*Participant directed to Q20 if respond "NEVER"

Q19. **How useful have you found the Child Trauma Questionnaire (CTQ)?**

- not useful at all (1)
- not very useful (2)
- moderately useful (3)
- very useful (4)
- extremely useful (5)

Q20. Traumatic Events Questionnaire (TEQ): The Traumatic Events Questionnaire (TEQ; Vrana & Lauterbach, 1994) is a self-report measure enquiring about specific traumatic events occurring in childhood and adulthood. Responses to the items are dichotomous (yes/no format). Additional information captured by the measure includes frequency, age of the individual at the time of the event(s), injury, threat to life and impact of event (past and present) (Vrana & Lauterbach, 1994).

In the past year, how often have you used this measure*?

- Never (1)
- Seldom (2)
- Sometimes (3)
- Often (4)
- Very often (5)

*Participant directed to Q22 if respond “NEVER”

Q21. How useful have you found the Traumatic Events Questionnaire (TEQ)?

- not useful at all (1)
- not very useful (2)
- moderately useful (3)
- very useful (4)
- extremely useful (5)

Q22. Trauma History Questionnaire (THQ) The Trauma History Questionnaire (THQ; Green, 1996) is a self-report measure that measures the experience of potentially traumatic events such as crime, general disaster, and sexual and physical abuse. Responses are dichotomous (yes/no format). Additional information captured by the measure includes the frequency, age at the time of the event and allows for the reporting of traumatic events or experiences not listed by the measure (Hooper, Stockton, Krupnick & Green, 2011).

In the past year, how often have you used this measure*?

- Never (1)
- Seldom (2)
- Sometimes (3)
- Often (4)
- Very often (5)

*Participant directed to Q24 if respond “NEVER”

Q23. How useful have you found the Trauma History Questionnaire (THQ)?

- not useful at all (1)
- not very useful (2)
- moderately useful (3)
- very useful (4)
- extremely useful (5)

Q24. Traumatic Life Events Questionnaire (TLEQ) The Traumatic Life Events Questionnaire (Kubany et al., 2000) is a self-report measure designed to measure the frequency of exposure to specific traumatic events. Some of the additional information captured by the measure includes the experience of "intense fear, helplessness or horror", relationship to perpetrator (if applicable), age of individual at time of exposure, whether the individual was injured or whether someone close to the individual was injured or died as a result (Kubany et al., 2000).

In the past year, how often have you used this measure*?

- Never (1)
- Seldom (2)
- Sometimes (3)
- Often (4)
- Very often (5)

*Participant directed to Q26 if respond "NEVER"

Q25. How useful have you found the Traumatic Life Events Questionnaire (TLEQ)?

- not useful at all (1)
- not very useful (2)
- moderately useful (3)
- very useful (4)
- extremely useful (5)

Q26. The Life Events Checklist (LEC) The Life Events Checklist (LEC), developed by the National Centre for PTSD, is a self-report measure enquiring about the exposure to traumatic events across the life span. The measure differentiates between different types of exposure including experiencing, witnessing or learning about traumatic events and allows for the inclusion of a traumatic event not listed or captured by the measure (Gray, Litz, Hsu & Lombardo, 2004).

In the past year, how often have you used this measure*?

- Never (1)
- Seldom (2)
- Sometimes (3)
- Often (4)
- Very often (5)

*Participant directed to Q28 if respond “NEVER”

Q27. How useful have you found the Life Events Checklist (LEC)?

- not useful at all (1)
- not very useful (2)
- moderately useful (3)
- very useful (4)
- extremely useful (5)

Q28. Have you used any other trauma history measures that we have not asked you about*?

□ Yes (1)

□ No (2)

*Participant directed to Q31 if respond "No"

Q29. **Please enter the name of *other* trauma history measures you have used in the left column.**

Use the rating scale to indicate how often you have used each trauma history measure *OVER THE PAST YEAR.*

Measure	**Never (1)**	**Seldom (2)**	**Sometimes (3)**	**Often (4)**	**Very Often (5)**
Measure (1)	□	□	□	□	□
Measure (2)	□	□	□	□	□
Measure (3)	□	□	□	□	□
Measure (4)	□	□	□	□	□
Measure (5)	□	□	□	□	□

Q30. **How useful have you found these measures?**

Measure	**Not useful at all (1)**	**Not very useful (2)**	**Moderately useful (3)**	**Very useful (4)**	**Extremely useful (5)**
Measure (1)	□	□	□	□	□
Measure (2)	□	□	□	□	□
Measure (3)	□	□	□	□	□
Measure (4)	□	□	□	□	□
Measure (5)	□	□	□	□	□

Q31. ***Section 4:***

This section asks more general questions regarding trauma history

Some studies have found discrepancies between trauma history identified through self-report trauma history measures and trauma history as documented in patient/client clinical notes.

When conducting routine clinical assessments, how often do you explicitly ask clients/patients about their trauma history?

(*Clinician and Clinician-Researchers only)

- Never (1)
- Seldom (2)
- Sometimes (3)
- Often (4)
- Very often (5)

Q32. How confident are you in your ability to enquire about a client's/patient's trauma history?

(*Clinician and Clinician-Researchers only)

- not confident at all (1)
- not very confident (2)
- moderately confident (3)
- very confident (4)
- extremely confident (5)

Q33. ***Section 5***

This section asks you to provide non-identifiable demographical information which we will use to describe the participants taking part in this study.

Are you male or female?

- Male (1)
- Female (2)

Q34. What is your age?

- 18-31 (1)
- 34-49 (2)
- 50-65 (3)
- 65+ (4)

35. What is the name of the country you currently live in?

- Australia (1)
- Canada (2)
- New Zealand (3)
- UK (4)
- Republic of Ireland (5)
- USA (6)
- Other (please specify) (7)
  _____

Q36. ***Section 6:***

This section allows you to comment more freely on trauma history measures.

Please use the text box below to include any comments you would like to make regarding trauma history measures (optional)

_____

_____

_____

_____

_____

Thank you for taking the time to fill out this survey.

The aim of this study is to evaluate trauma history measures from the perspective of clinicians and researchers who work within the field of trauma. The information you have provided will help to inform our understanding as to what trauma history measures are being used in clinical and research practice and whether trauma history measures are considered useful.

If you have any questions or queries in relation to any aspect of this study, or would like to request summary conclusions from this study, you may contact the researchers using the following email address: lcoyle20@qub.ac.uk OR donncha.hanna@qub.ac.uk

Appendix D

Description of pilot phase

"Following the draft of the first survey, the survey was piloted on two clinician-researchers (September/October 2016). As the survey had not yet been uploaded to Qualtrics, the survey was presented in Microsoft word format. Both participants experienced difficulty completing the survey, given the number of filter questions which were difficult to complete as the survey was not set up using the appropriate program at this stage. One participant also found it difficult to answer a question regarding the frequency of use of trauma history measures, given the dichotomous response options provided (YES/NO) and the lack of clarity as to whether questions were related to clinical or research activity. This prompted revisions to the survey by the team.

1) The question referenced above was changed to the following: "How often do you use trauma history measures in your clinical and/or research activity" (Q10, pp 106) to improve clarity and also to improve response options to those recommended by the literature (change to ordinal response categories, as per Barker (1999). Another change was made here to allow participants who identified using trauma history measures "seldom, sometimes, often and very often" to answer Q12 (factors that discourage use of measures). This was to facilitate participants who use measures to have the opportunity to identify factors that may discourage them from doing so.
2) Following the initial pilot revealing difficulties for clinician-researchers differentiating between clinical and research use of measures, clinician-researchers were asked to rate the utility of measures in clinical practice and also in research practice in separate questions. Therefore, the question relating to utility of measures in clinical practice was only presented to clinicians and clinician-researchers and the

question relating to utility of measures in research was only presented to clinician-researchers and researchers (Q13 and Q14, pp 109).

3) Eating disorders and Personality Disorders were included as presentations in Q15 (pp 110), given the association between trauma and these disorders (Ball & Links, 2009; Brewerton, 2007; Wota et al., 2004).
4) Previously, Q15 (presentations) and Q16 (features of measures) (pp 110-113) appeared towards the end of the survey. This was amended to improve the flow of the survey (e.g. move from generic to specific).
5) Phrasing change was made to Section 6 to include "This section allows you to comment more freely on trauma history measures" (pp 121) as per Fink (2009). The word "optional" was included after this question, as well as the open ended question regarding the features of trauma history measures, (pp 113) to ensure participants were aware this was not a mandatory section of the survey.
6) Final section of the survey (pp 122) amended to include synopsis of purpose of study.

At this point, the survey was uploaded to Qualtrics. A significant amount of time was spent uploading questions, choosing appropriate format, adding filter questions and ensuring the efficiency of same. Following this, the survey was reviewed by the research team using the Qualtrics software. Some spelling errors were highlighted through this process and Q15 (pp 110) was opened up to researchers also. This was to ensure more equality within the survey and to gather more information.

The survey was then piloted with eight participants (clinicians, researchers and clinician-researchers), one of whom included an expert in trauma. No issues or difficulties were reported and participants reported that the survey took no longer than 10 mins to complete.

During the pilot process, it was identified that “Intellectual Disability” had been accidentally omitted in Q15 (pp 110) and the survey was amended to include this, given findings of Donohoe (2010) (professionals less likely to ask about trauma history if cognitive impairments present). Data collection commenced on 1st April 2017”.

Appendix E

Email to participants to invite participation in survey

This information appeared in the email communication to participants whose contact details (i.e. email address) have been retrieved as provided as part of their publications.

Email subject: An Evaluation of Trauma History Measures

Dear (Title and name),
My name is *Lisa Coyle* and I am a Trainee Clinical Psychologist at Queen's University Belfast, Northern Ireland. As part of my training, I am conducting an evaluation of trauma history measures from the perspective of researchers and clinicians.

We retrieved your email contact details as provided as part of your publication(s) in the area of trauma.

We are specifically interested in the view of clinicians who are likely to encounter traumatic presentations in their day-to-day clinical practice and also researchers who work within the field of trauma. If you are interested in taking part, you are invited to complete an anonymous online survey that that will take approximately ten minutes to complete.

To access further information on the study and to complete the survey, please click the following link (insert link to survey).

You are invited to circulate the link to this survey to your colleagues who may also be interested in this study.

Regards,
Lisa Coyle

Trainee Clinical Psychologist
Queens's University Belfast
Belfast
Northern Ireland

This information will appear in the email advertisement to participants whose contact details were retrieved via another source (i.e. to individuals in academic institutions, trauma centres and clinics, projects, organisations etc).

Email subject: An Evaluation of Trauma History Measures

Dear (title and name),
My name is *Lisa Coyle* and I am a Trainee Clinical Psychologist at Queen's University Belfast, Northern Ireland. As part of my training, I am conducting an evaluation of trauma history measures from the perspective of researchers and clinicians.

We are specifically interested in the view of clinicians who are likely to encounter traumatic presentations in their day-to-day clinical practice and also researchers who work within the field of trauma. If you are interested in taking part, you are invited to complete an anonymous online survey that that will take approximately ten minutes to complete.

To access further information on the study and to complete the survey, please click the following link (insert link to survey).

You are invited to circulate the link to this survey to your colleagues who may also be interested in this study.

Regards,

Lisa Coyle
Trainee Clinical Psychologist
Queen's University Belfast
Belfast
Northern Ireland

Appendix F

Important features of trauma history measures

Table 2

Features of trauma history measures

Feature	Not important at all	Not very important	Moderately important	Very important	Extremely important
Provides a comprehensive assessment/measurement of trauma history (i.e. history, severity, impact, frequency, typology)	7 (1.3%)	20 (3.8%)	96 (18.2%)	241 (45.6%)	164 (31.1%)
Satisfactory psychometric properties (e.g. validity and reliability)	14 (2.7%)	30 (5.7%)	116 (22.0%)	215 (40.7%)	153 (29.0%)
Assesses a range of traumatic events and experiences	10 (1.9%)	12 (12.3%)	68 (12.9%)	239 (45.3%)	199 (37.7%)
Assess features of complex trauma (i.e. a unique history of prolonged, repeated traumatic events in order to discriminate from circumscribed trauma history (i.e. “simple”, one off trauma)	9 (1.7%)	28 (5.3%)	104 (19.7%)	230 (43.6%)	157 (29.7%)
Includes quantitative descriptors of trauma (e.g. severity, frequency, age, impact)	13 (2.5%)	31 (5.9%)	113 (21.4%)	245 (46.4%)	136 (23.9%)
Has a clear and operationalised definition of trauma	13 (2.5%)	48 (9.1%)	136 (25.8%)	207 (39.2%)	124 (23.5%)

Appendix F

Important features of trauma history measures

Table 2

Features of trauma history measures

Feature	Not important at all	Not very important	Moderately important	Very important	Extremely important
Elicits information in a sensitive and non-intrusive manner	9 (1.7%)	19 (3.6%)	86 (16.3%)	211 (40.0%)	203 (38.5%)
Uses clear and accessible language and is presented clearly	7 (1.3%)	10 (1.9%)	47 (8.9%)	210 (39.8%)	254 (48.1%)
Short administration/completion time	14 (2.7%)	21 (4.0%)	174 (33.0%)	200 (37.9%)	119 (22.5%)

Appendix G

Additional open ended responses regarding important features of trauma history measures

A total of 124 responses were received, 43.5% from clinician-researchers, 34.7% from clinicians and 21.8% from researchers. The most salient features of trauma history measures according to participants included the capacity of trauma history measures to provide an assessment of symptoms (i.e. PTSD symptoms, dissociation) and/or contextual factors (i.e. family factors, risk) (*n* = 23). 21 participants identified the need for specific questioning styles and/or formats, such as the need for measures to allow for participants to describe their subjective experience (e.g. open ended questions) (*n* = 9), the need for questions that are behaviourally specific or defined (*n* = 5), other types of questions (age/timing of exposure, follow up questions, therapist observations etc.) (*n* = 7).

Mirroring the quantitative responses, participants also expressed the need for measures that are accessible (e.g. language, visual format, cost) and sensitive (i.e. culturally and developmentally appropriate) (*n* = 15), capable of assessing a range of experiences and events (*n* = 10), capable of assessing for complex and/or multiple traumatic events Vs single traumas (*n* = 5) as well as capable of providing accurate, valid and reliable measurements of trauma (*n* = 5). Additional responses included measures being able to facilitate diagnosis or map onto diagnostic criterion (*n* = 5) and differentiate between potential traumatic exposure and traumatic exposure (*n* = 5). The remaining responses included comments on the survey (*n* = 7), the identification of specific measures (*n* = 2), pros and cons of trauma history measures (*n* =19), the influence of context in determining features of trauma history measures (*n* = 7) as well as 10 uncategorised responses.

Appendix H

The utility of trauma history measures with different clinical presentations

Table 3

Utility of trauma history measures with various presentations

Presentation	Not useful at all	Not very useful	Moderately useful	Very useful	Extremely useful
Depression (mild/moderate)	14(2.7%)	40(7.6%)	179(33.9%)	195(36.9%)	100(18.9%)
Severe Depression	18(3.4%)	52(9.9%)	150(28.4%)	206(39.0%)	102(19.3%)
Anxiety Disorder (e.g. GAD, OCD)	16(3.0%)	31(5.9%)	160(30.3%)	214(40.5%)	107(20.3%)
Psychosis	36(6.8%)	74(14.0%)	161(30.5%)	163(30.9%)	94(17.8%)
Alcohol/Substance misuse	18(3.4%)	41(7.8%)	125(23.7%)	212(40.2%)	132(25.0%)
Bipolar Disorder	19(3.6%)	56(10.6%)	185(35.0%)	178(33.7%)	90(17.1%)
PTSD/Trauma	10(1.9%)	15(2.8%)	62(11.7%)	157(29.7%)	284(53.8%)
Complex PTSD	10(1.9%)	26(14.9%)	61(11.6%)	152(28.8%)	279(52.8%)
Suicidal Ideation/Self-harm/Risk	18(3.4%)	40(7.6%)	132(25.0%)	193(36.6%)	145(27.5%)
ADHD	42(18.0%)	108(20.5%)	191(36.2%)	127(24.1%)	60(11.4%)
Personality Disorder	21(4.0%)	45(8.5%)	143(27.1%)	189(25.8%)	130(24.6%)
Eating Disorders	22(4.2%)	37(7.0%)	171(32.4%)	191(36.2%)	107(20.3%)
Intellectual Disability	64(12.1%)	143(27.1%)	187(34.4%)	94(17.8%)	40(7.6%)

Appendix I

Open ended responses to question on reasons or factors encouraging use of trauma history measures

46 participants provided an "other" response in relation to this question which asked participants to indicate their reasons for using trauma history measures. 37% of responses were from clinician-researchers, 41.3% were from researchers and 21.7% were from clinicians. Overall, responses corroborated with the quantitative responses and/or response options provided to this question. 10 participants identified the impact of trauma on mental health and outcomes and its relationship with other presentations as encouraging the use of trauma history measures. 9 participants identified the capacity for trauma history measures to help to facilitate or guide the therapeutic process, intervention or treatment plan as encouraging the use of trauma history measures.

Deviating from the quantitative responses provided additional information included 8 participants who reported the use of trauma history measures to facilitate various aspects of the research process (e.g. "*To screen for eligibility in my studies*"). 6 participants reported the use of trauma history measures to evaluate therapeutic, intervention or treatment outcomes. 4 participants noted a discrepancy between the use of trauma history measures between clinical and research practice with participants reporting to either use trauma history measures more in research than clinical practice, or perceive trauma history measures to be more suitable in research. Additionally, 3 participants reported that trauma history measures are a requirement by other agencies. Finally, 3 responses were uncategorized and 3 participants reported to not use trauma history measures and/or use other methods.

Appendix J

Open ended responses to question on factors that discourage use of trauma history measures

Participants were asked to indicate factors that discourage use of trauma history measures. “Other” responses were provided by 79 participants where 43% of these responses were from clinicians, 34.2% were from clinician-researchers and 22.8% of responses were from researchers. Some responses corroborated with the quantitative responses to the question while others provided new insights into factors that may discourage the use of trauma history measures. Deviating from the quantitative responses, participants noted time, service and/or organizational constraints in using trauma history measures (*n* = 17*)*. In fitting with quantitative responses, participants expressed concern that that measures are not always appropriate or suitable for use with certain populations or presentations (*n* = 12) and reported a tendency or preference to use other methods or approaches (*n* = 11).

Additional responses included potential for re-traumatisation, burden or disruption to therapeutic relationship (*n* = 9), while in line with the quantitative responses to this question, 5 participants raised concerns regarding the conceptualisation of trauma. 4 participants (clinician-researchers) noted a discrepancy between the use of trauma history measures between clinical and research practice with participants reporting to use trauma history measures more in research than clinical practice. Other participants identified the use of trauma history measures as inconsistent with their approach (*n* = 3), and in line with quantitative responses, reported concerns re validity and reliability of measures and/or trauma histories in general (*n* = 2). 10 responses were uncategorized and 6 participants reported use of trauma history measures, with 3 of these participants acknowledging use of measures irrespective of limitations.

Appendix K

Responses to generic open ended question

Participants were provided with an optional open ended question to comment more freely on trauma history measures towards the end of the survey. 102 responses were received in total, with 46.1% of responses from clinician-researchers, 36.3% from clinicians and 17.6% from researchers.

23 participants reported either the use of alternative methods of assessing trauma history and/or the use of additional methods in conjunction with trauma history measures *"I don't see the point in doing all these measures when the history and impact of trauma is revealed through skillful and sensitive questioning"* and *"These measures can be used adjunct to thorough clinical assessment".*

18 participants commented on the need for accessible measures, including measures that are brief or have short completion or administration times (n = 8) *"In clinical practice, we need short trauma history measures",* the need for measures that are appropriate for specialized settings and/or to use with certain populations or presentations (n = 9) "*Often difficult to use with psychosis service users*" and measures that are free (n = 1)

Additionally, 12 participants highlighted the need for clinical judgement, skill and/or putting the client first when assessing trauma history or using trauma history measures *"most important thing is safe therapeutic relationship and using the measures carefully, at the right time and appropriately. Need to be a confident clinician I feel before handing out trauma measures".* Information on additional responses are provided in Table 4.

Table 4

Additional responses to general open ended question

Code	n
Comments on survey	20
"Other" uncategorized responses	10
Identification of specific instruments	9
The need for trauma history measures that can assess a wide range of experiences Vs the need for trauma history measures that measure specific trauma types	6
The importance of assessing trauma history or using trauma history measures, given the association between trauma and other presentations	5
The need for further research and development into the psychometric properties of measures	4
Measures that are non-intrusive	3
The need for quantitative descriptors of trauma events	2
Discrepancy between clinical and research practice	3
Trauma history measures can facilitate assessment and therapeutic process	2

Appendix L

Frequency of use of CTQ, THQ, TEQ, TLEQ and LEC across groups

Table 5

Percentage frequency of the CTQ by group

Group	Never	Seldom	Sometimes	Often	Very often
Clinician	72.4(131)	13.3(24)	9.9%(18)	3.3%(6)	1.1%(2)
Researcher	46.1%(53)	13.9%(16)	13.0%(15)	9.6%(11)	17.4%(20)
Clinician-Researcher	52.2%(121)	9.5%(22)	15.9%(37)	9.9%(23)	12.5%(29)

Table 6

Percentage frequency of the TEQ by group

Group	Never	Seldom	Sometimes	Often	Very often
Clinician	79.0%(143)	8.8%(16)	9.4%(17)	2.2%(4)	0.6%(1)
Researcher	74.8%(86)	8.7%(10)	12.2%(14)	3.5%(4)	0.9%(1)
Clinician-Researcher	65.1%(151)	15.1%(35)	9.5%(22)	3.9%(9)	6.5%(15)

Table 7

Percentage frequency of the THQ by group

Group	Never	Seldom	Sometimes	Often	Very often
Clinician	82.9%(150)	9.4%(17)	6.1%(11)	1.7%(3)	0.0%(0)
Researcher	79.1%(91)	9.6%(11)	7.0%(8)	2.6%(3)	1.7%(2)
Clinician-Researcher	64.2%(149)	10.8%(25)	15.1%(35)	5.6%(13)	4.3%(10)

Table 8

Percentage frequency of the TLEQ by group

Group	Never	Seldom	Sometimes	Often	Very often
Clinician	85.1%(154)	7.2%(13)	3.9%(7)	2.2%(4)	1.7%(3)
Researcher	71.3%(82)	6.1%(7)	12.2%(14)	7.0%(8)	3.5%(4)
Clinician-Researcher	61.6%(143)	9.9%(23)	11.2%(26)	7.8%(18)	9.5%(22)

Table 9

Percentage frequency of the LEC by group

Group	Never	Seldom	Sometimes	Often	Very often
Clinician	72.4%(131)	9.4%(17)	6.6%(12)	6.6%(12)	5.0%(9)
Researcher	47.8%(55)	7.0%(8)	14.8%(17)	13.9%(16)	16.5%(19)
Clinician-Researcher	43.1%(100)	9.1%(21)	12.9%(30)	14.2%(33)	20.7%(48)

Appendix M

Table 10

Utility of the CTQ by professional group

	Not Useful		Moderately Useful		Very Useful	
	Percent	n	Percent	n	Percent	n
Clinician	4.0	2	62.0	31	34.0	17
Researcher	3.2	2	32.3	20	64.5	40
Clinician-Researcher	7.2	8	35.1	39	57.7	64

Table 11

Utility of the TEQ by professional group

	Not Useful		Moderately Useful		Extremely useful	
	Percent	n	Percent	n	Percent	n
Clinician	10.5	4	68.4	26	21.1	8
Researcher	6.9	2	51.7	15	41.4	12
Clinician-Researcher	9.9	8	53.1	43	37.0	30

Table 12

Utility of the THQ by professional group

	Not Useful		Moderately Useful		Extremely Useful	
	Percent	n	Percent	n	Percent	n
Clinician	12.9	4	54.8	17	32.3	10
Researcher	8.3	2	41.7	10	50.0	12
Clinician-Researcher	8.4	7	53.0	44	38.6	32

Table 13

Utility of the TLEQ by professional group

	Not at all useful		Moderately useful		Extremely useful	
	Percent	n	Percent	n	Percent	n
Clinician	7.4	2	55.6	15	37.0	10
Researcher	0.0	0	45.5	15	54.5	18
Clinician-Researcher	3.4	3	47.2	42	49.4	44

Table 14

Utility of the LEC by professional group

	Not Useful		Moderately Useful		Extremely Useful	
	Percent	n	Percent	n	Percent	n
Clinician	8.0	4	54.0	27	38.0	19
Researcher	1.7	1	41.7	25	56.7	34
Clinician-Researcher	3.8	5	37.9	50	58.3	17

Appendix N

Consideration of statistical analysis

Differences between clinicians, researchers and clinician-researchers were explored in this study with regards to frequency of use of trauma history measures and the utility of trauma history measures (generally and in relation to specific measures). Chi square analyses were also used to look at differences between these groups on sample characteristics (e.g. age and gender).

Twenty-two chi squares were conducted overall in the study. Thirteen of these analyses met the assumptions of chi square analyses (e.g. the use of categorical/ordinal data, mutually exclusive categories, expected cell frequencies greater than one, 80% of cells with an expected frequency of at least 5). Given that this study dealt with survey data (i.e. clinician and researcher experience and opinion), in some cases, the latter assumption was violated in a small number of cases. Re-coding of scale responses assisted in reducing violations of assumptions. Fisher's exact test, which is recommended when expected cell count is less than five (Kim, 2017), was calculated using an online calculator which facilitates a maximum of 6 x 6 tables, where cell values must be less than one hundred. There were no differences with regards to the statistical significance of findings between Fisher's test and the Chi square analyses when both tests were compared when looking at group differences on the utility of each of the specific trauma history measures (e.g. CTQ, THQ…etc). Therefore, the first author made the decision to report the findings for the chi square analysis, given that Fisher's exact test is usually used with nominal data (McDonald, 2009).

Appendix O

Journal format instructions

Author Guidelines

1. **Online Submissions:** The *Journal of Traumatic Stress* accepts submission of manuscripts online at: http://mc.manuscriptcentral.com/jots Information about how to create an account or submit a manuscript may be found online on the Manuscript Central homepage in the "User Tutorials" section or, on the Author Dashboard, via the "Help" menu in the upper right corner of the screen. Personal assistance also is available by calling 434-964-4100.

2. **Article Formats:** Three article formats are accepted for consideration by JTS. All page counts should include references, tables, and figures. *Regular articles* (30 pages maximum, inclusive of all text, abstract, references, tables, and figures) include research studies, quantitative systematic reviews, and theoretical articles. Purely descriptive articles or narrative-based literature reviews are rarely accepted. In extraordinary circumstances, the editors may consider longer manuscripts that describe highly complex designs or statistical procedures but authors should seek approval prior to submitting manuscripts longer than 30 pages. *Brief reports* (18 pages maximum) are appropriate for pilot studies or uncontrolled trials of an intervention, preliminary data on a new problem or population, condensed findings from a study that does not merit a full article, or methodologically oriented papers that replicate findings in new populations or report preliminary data on new instruments. *Commentaries* (1,000 words or less) involve responses to previously published articles or, occasionally, invited essays on a professional or scientific topic of general interest. Response commentaries, submitted no later than 8 weeks after the original article is published (12 weeks if outside the U.S.), must be content-directed and use tactful language. The original author is given the opportunity to respond to accepted commentaries.

3. **Double-Blind Review:** As of January 1, 2017, the Journal of Traumatic Stress utilizes a double-blind review process in which reviewers receive manuscripts with no authors' names or affiliations listed in order to ensure unbiased review. To facilitate blinded review, the title page should be uploaded as a separate document from the body of the manuscript, identified as "Title Page," and should include the title of the article, the running head (maximum 50 characters) in uppercase flush left, author(s) byline and institutional affiliation, and author note (see pp. 23-25 of the APA 6th ed. manual). Within the main body of the manuscript, tables, and figures, authors should ensure that any identifying information (i.e., author names, affiliations, institutions where the work was performed, university whose ethics committee approved the project) is blinded; a simple way to accomplish this is by replacing the identifying text with the phrase "[edited out for blind review]". In addition, language should be used that avoids revealing the identity of the authors; e.g., rather than stating, "In other research by our lab (Bennett & Kerig, 2014), we found …" use phrases such as, "In a previous study, Bennett and Kerig (2014) found …" Please note that if you have uploaded the files correctly, you will **not** be able to view the title page in the PDF and HTML proofs of your manuscript; however, the Editor and JTS editorial office staff can view this information.

4. **Preferred and Non-Preferred Reviewers:** During the submission process, authors may suggest the names of preferred reviewers; authors also may request that specific individuals not be selected as reviewers.

5. **Publication Style:** JTS follows the style recommendations of the 2010 *Publication Manual of the American Psychological Association* (APA; 6th edition) and submitted manuscripts must conform to these formatting guidelines. Manuscripts should use non-sexist

language. Manuscripts must be formatted using letter or A4 page size, with 1 inch (2.54 cm) margins on all sides, Times New Roman 12 point font (except for figures, which should be in 12 point Arial font), and double-spacing for text, tables, references, and figures. Submit your manuscript in DOC or RTF format. For assistance with APA style, in addition to consulting the manual itself, please note these helpful online sources that are freely available: http://www.apastyle.org/learn/tutorials/basics-tutorial.aspx and https://owl.english.purdue.edu/owl/section/2/10/ .

6. **APA and JTS Style Pointers:** In addition to consulting the APA 6th edition Publication Manual, the resources indexed above, and the JTS Style Sheet posted online, please consider these pointers when formatting each section of the manuscript:

a. **Tense:** Throughout the manuscript, please use past tense for everything that has already happened, including the collection and analyses of the data being reported.

b. **Abstract:** The Main Document of the manuscript should begin with an abstract no longer than 250 words, placed on a separate page. In addition, JTS house style requires the reporting of an effect size for each finding discussed in the abstract; if there are many findings, present the range.

c. **Participants:** Please include in this subsection of the Method section information on sample characteristics, subsample comparisons, and analyses that describe the sample but are not focused on testing the hypotheses that are the aims of your manuscript.

d. **Procedure:** Please describe the procedure in sufficient detail so that it could be comprehended and replicated by another investigator. Identify by name the IRB or ethics committee (edited out for blind review in the submitted manuscript) that approved the research, and the manner in which consent was obtained.

e. **Measures:** In addition to providing citations, psychometric, and validation data for each measure administered, please provide coefficient alpha from your data for each measure for which this is appropriate.

f. **Data Analysis:** Include a separate subsection with this header in the Method section in which you describe the analyses performed, the software program(s) used, and make an explicit statement about missing data in your data set. If there are no missing data, so state; otherwise describe the extent of missing data and how they were handled in the data analyses.

g. **Results** (and throughout): Please present percentages to 1 decimal place, means and *SD*s to 2 decimal places, and exact *p* values to 3 decimal places except for < .001. Include leading zeros (e.g., 0.92) when reporting any statistic that can be greater than 1.00 (or less than -1.00). For example, there is no leading zero used when reporting correlations, coefficient alphas, standardized betas, *p* values, or fit indices (e.g., *r* = .47, not 0.47).

h. **References:** Format the references using APA 6th edition style: (a) begin the reference list on a new page following the text, (b) double-space, (c) use hanging indent format, (d) italicize the journal name or book title, and (e) list alphabetically by last name of first author. Do not include journal issue numbers unless each volume begins with page 1. If a reference has a Digital Object Identifier (doi), it must be included as the last element of the reference.

(1) *Journal Article:*

Kraemer, H. C. (2009). Events per person-time (incidence rate): A misleading statistic? *Statistics in Medicine, 28*, 1028–1039. doi: 10.1002/sim.3525

(2) *Book:*

Cohen, J. (1988). *Statistical power analysis for the behavioural sciences* (2nd ed.). Hillsdale, NJ: Erlbaum.

(3) *Book Chapter:*

Meehl, P. E. (2006). The power of quantitative thinking. In N. G. Waller, L. J. Yonce, W. M. Grove, D. Faust, & M. F. Lenzenweger (Eds.), *Essays on the practice of scientific psychology* (pp. 433–444). Mahwah, NJ: Erlbaum.

i. **Footnotes:** Footnotes should be avoided. When their use is absolutely necessary, footnotes should be formatted in APA style and placed on a separate page after the reference list and before any tables.

j **Tables:** Tables should be formatted in APA 6th edition style and should be placed after the references in the body of the manuscript. Please use Word's Table function to construct tables, not tabs and spacing. Tables should be numbered (with Arabic numerals) and referred to by number in the text. Each table should begin on a separate page. Please make tables double-spaced, decimal align all numeric columns, and use sentence case for labels. Each datum should appear in its own cell (e.g., do not include *SDs* in parentheses following *M*s but instead create a separate column for *SD*s). When reporting a table of intercorrelations, fill the rows first and then the columns such that any empty cells are in the lower left-hand quadrant of the table; use dashes in any redundant cells indicating the correlation of a variable with itself. Please use asterisks to indicate significance levels in tables, not *p* values. **Color in tables:** Color can be included in the online version of a manuscript at no charge; however use of color in the print version of the journal will incur additional charges (currently $600 per figure or table). If you wish to include color in only the online version, please ensure that each table will be legible in greyscale when it is published in the print version; for example, lines of different colors may be discriminable from one another when viewed in color but may not appear to be different from one another in greyscale.

k. **Figures:** All figures (graphs, photographs, drawings, and charts) should be numbered (with Arabic numerals) and referred to by number in the text. Each figure should begin on a separate page. Place figures captions at the bottom of the figure itself, not on a separate page. Include a separate legend to explain symbols if needed. Please use Arial font throughout except for the caption, which should remain as Times New Roman. Use sentence case for titles and labels. Figures should be in Word, TIF, or EPS format.

L**.** **Color in figures:** Color can be included in the online version of a manuscript at no charge; however use of color in the print version of the journal will incur additional charges (currently $600 per figure or table). If you wish to include color in only the online version, please ensure that each figure will be legible in greyscale when it is published in the print version; for example, lines of different colors may be discriminable from one another when viewed in color but may not appear to be different from one another in greyscale.

7. **Uploading Files:** After the separate Title Page has been uploaded, the remaining text (abstract, main body of the manuscript, references, and tables) should be uploaded as a **single** file designated as "Main Document." Figures may be either included in the main document or uploaded as separate files if in a non-Word format.

8. **Supplementary Materials.** Authors may wish to place some material in the separate designation of "Supplementary file not for review," which will be made available online for optional access by interested readers. This material will not be seen by reviewers and will not be taken into consideration in their evaluation of the scientific merits of the work, and will not be included in the published article. Material appropriate for such a designation includes information that is not essential to the reader's comprehension of the study design or findings, but which might be of interest to some scholars; examples might include

descriptions of a series of non-significant post-hoc analyses that were not central to the main hypotheses of the study, detailed information about the content of coding system categories, and CONSORT flow diagrams for randomized controlled trials (see below). Note well that the manuscript must stand on its own without this material; consequently, critical information reviewers and readers need to evaluate or replicate the study, such as the provenance and psychometric properties of the measures administered, is not appropriate for placement into Supplementary Materials.

9. **Statement of Ethical Standards:** In the conduct of their research, author(s) are required to adhere to the "Ethical Principles of Psychologists and Code of Conduct" of the American Psychological Association (visit http://www.apa.org/science/leadership/research/ethical-conduct-humans.aspx for human research or http://www.apa.org/science/leadership/care/guidelines.aspx for animal research) or equivalent guidelines in the study's country of origin. If the author(s) were unable to comply when conducting the research being presented, an explanation is required.

All work submitted to the *Journal of Traumatic Stress* must conform to applicable governmental regulations and discipline-appropriate ethical standards. Responsibility for meeting these requirements rests with all authors. Human and animal research studies typically require prior approval by an institutional research or ethics committee that has been established to protect the welfare of human or animal participants. Data collection for the purposes of providing clinical services or conducting an internal program evaluation generally does not require approval by an institutional research committee. However, analysis and presentation of such data outside the program setting may qualify as research (which is defined as an effort to produce generalizable knowledge) and thus may require approval by

an institutional committee. Those who submit manuscripts to the *Journal of Traumatic Stress* based on data from these sources are encouraged to consult with a representative of the applicable institutional committee to determine whether approval is needed. Presentations that report on a particular person (e.g., a clinical case) also usually require written permission from that person to allow public disclosure for educational purposes, and involve alteration or withholding of information that might directly or indirectly reveal identity and breach confidentiality. To document how these guidelines have been followed, authors are asked to identify in the online submission process the name of the authorized institution, committee, body, entity, or agency that reviewed and approved the research or that deemed it to be exempt from ethical or Internal Review Board review. Although blinded at the time of submission, the name of the IRB or ethics committee that approved the research, and the manner in which consent was obtained, also should appear in the Procedure subsection of the Method in the body of the report.

10. **Randomized Clinical Trials:** Reports of randomized clinical trials should include a flow diagram and a completed CONSORT checklist (available at http://www.consort-statement.org) indicating how the manuscript follows CONSORT Guidelines for the reporting of randomized clinical trials. The flow diagram should be included as a figure in the manuscript whereas the checklist should be designated as a "Supplementary file not for review" during the online submission process. Please visit http://consort-statement.org for information about the consort standards and to download necessary forms.

11. **Systematic Reviews:** Reports of systematic reviews follow the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines (http://www.prisma-statement.org/documents/PRISMA%202009%20checklist.pdf) and should be accompanied

by a flow diagram (http://www.prisma-statement.org/PRISMAStatement/FlowDiagram.aspx) mapping out the number of records identified, included, and excluded, and the reasons for exclusions.

12. **Writing for an International Readership:** As an international journal, the *Journal of Traumatic Stress* avoids the use of operational code names or nicknames to describe military actions, wars, or conflicts, given that these may not be equally familiar or meaningful to readers from other nations. Helpful guides for clear and neutral language for reporting on military-based research can be found at the following webpages: the ISTSS newsletter *StressPoints* (http://www.istss.org/education-research/traumatic-stresspoints/2015-march-(1)/media-matters-what%E2%80%99s-in-a-name-using-military-code.aspx), the *International Press Institute* (http://ethicaljournalismnetwork.org/assets/docs/197/150/4d96ac5-55a3396.pdf) and the *Associated Press Stylebook and Briefing on Media Law* (http://www.apstylebook.com/?do=help&q=48/). In addition, authors are encouraged to give consideration to whether particular research findings might be culturally-specific rather than universally established; e.g., prevalence rates derived from samples consisting of all-US participants should be identified as such.

13. **Originality and Uniqueness of Submissions.** Submission is a representation that neither the manuscript nor substantive content within in it has been published previously nor is currently under consideration for publication elsewhere. A statement transferring copyright from the authors (or their employers, if they hold the copyright) to the International Society for Traumatic Stress Studies will be required after the manuscript has been accepted for publication. Authors will be prompted to complete the appropriate Copyright Transfer

Agreement through their Author Services account. Such a written transfer of copyright is necessary under U.S. Copyright Law in order for the publisher to carry through the dissemination of research results and reviews as widely and effectively as possible.

14. **Pre-Submission English-Language Editing:** Authors for whom English is a second language may choose to have their manuscript professionally edited before submission to improve the English. Japanese authors can find a list of local English improvement services at http://www.wiley.co.jp/journals/editcontribute.html. All services are paid for and arranged by the author, and use of one of these services does not guarantee acceptance or preference for publication.

15. **Page Charges:** The journal makes no page charges. The only exception to this, as noted above, is if authors wish tables or figures to be printed in color.

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benefits the service offers. Should you wish to purchase reprints of your article, please click on the link and follow the instructions provided: https://caesar.sheridan.com/reprints/redir.php?pub=10089&acro=JTS

17. **OnlineOpen** : The *Journal of Traumatic Stress* accepts articles for Open Access publication. Please visit http://olabout.wiley.com/WileyCDA/Section/id-828081.html for further information about OnlineOpen.

18. **NIH Public Access Mandate:** For those interested in the Wiley-Blackwell policy on the NIH Public Access Mandate, please visit our policy statement at www.wiley.com/go/nihmandate

Reflective Appendix

Even prior to receiving an introduction to the research components of the course, I can recall feeling anxious about the prospect of embarking on the research process and doubted my abilities to see this through. A competent CBT therapist may have asked me to consider the evidence for this doubt and actually, there existed little concrete evidence to base this upon, having successfully completed dissertations and undergraduate and postgraduate level. It is important to acknowledge the patience, sensitivity and compassion of my supervising research team who provided me with not only guidance and practical support surrounding the research project, but also the emotional containment I needed to complete this project.

This was not a project I was initially drawn to, mostly because of my self-doubt. A project on trauma history measures was sure to reveal me as a fraud and my lacking knowledge on statistical constructs. However, conversations with the research team allowed me to see this project differently and soon I was drawn to the challenge of this project, allured by the novelty and potential implications for clinical and research practice.

I have realized that contributing to my anxiety and self-doubt was my erroneous thinking in that research at this level is solely about complex methodologies and statistical procedures. Supervision, classes on research throughout the programme and the experience of completing this project in particular has taught me that completing doctorate level research requires a much wider range of skills, many of which I have developed over the past three years whilst completing this project; including study development within the context of a team, survey design (informed by theory and literature), preparation and submission to ethics, developing sample recruitment strategies and managing large amounts of data, analysis as well as the communication and dissemination of findings including presentations and written formats (in line with journal requirements).

The most challenging aspect of completing this project was the development of the survey itself with the daunting task of developing a survey that is accessible to a wide variety of professions in research and clinical practice and a survey that is concise and brief but also allows participants to express their views. In retrospect, there are some changes I would make, including amending the wording of some questions to make them clearer to participants.

I particularly enjoyed the networking aspect of this project and making contact with a range of clinicians and researchers internationally, many of whom were very interested in this project and the large and international sample size was a strength of this study. I also enjoyed sharing some of the literature and discussing this research with supervisors on various placements. This facilitated collaboration with supervisors to consider how traumatic exposure was being assessed by the service, leading to change in protocols in one particular placement. In this way, I have directly applied aspects of this project to my own clinical practice as well as the practice of others.

I was surprised by the large number of self-identified clinician-researchers who took part in this study, particularly given that the majority of participants were Clinical Psychologists and there has previously been concern over the lack of Clinical Psychologists engaging in research post qualification. Whilst acknowledging the potential for significant variation across this group with regards to research activities, I am hoping that I continue to engage in research activity in a meaningful way post-training.